The Modern Hospital

JULY 1961

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Pattern Illustrated is Linen Weave

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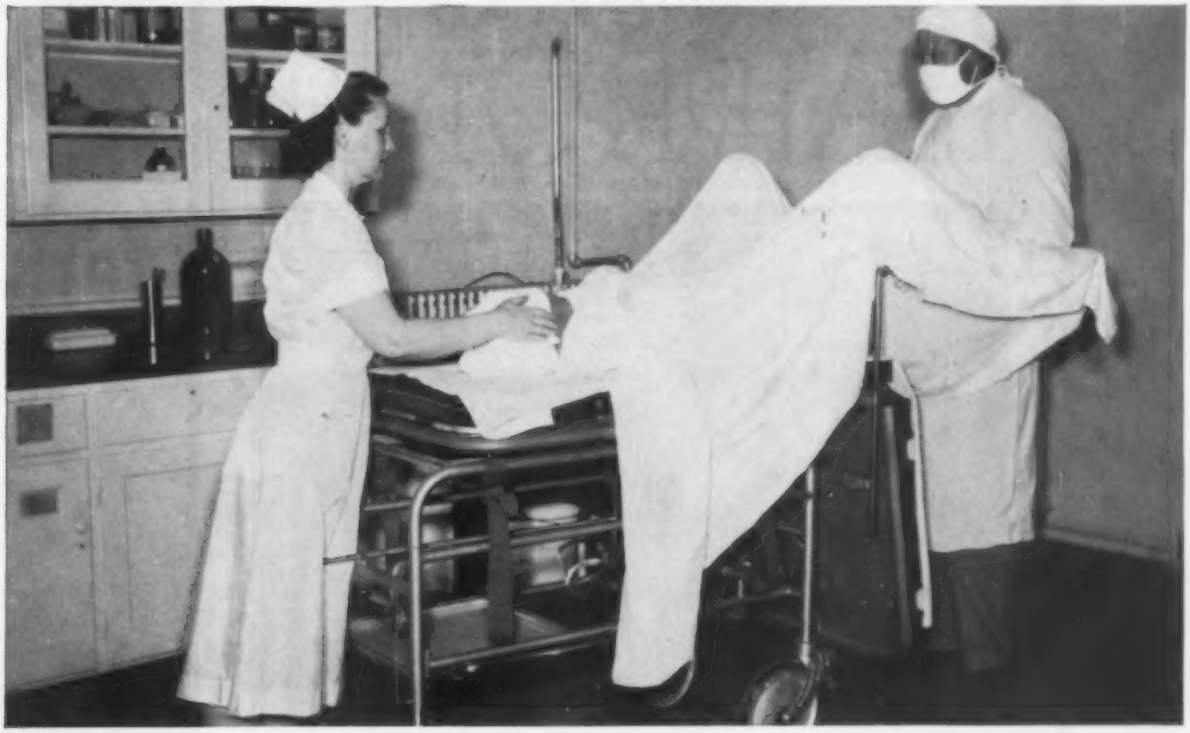

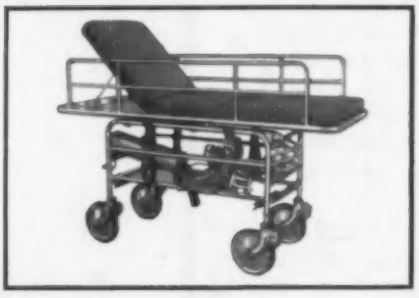

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The Modern Hospital

JULY 1961 VOLUME 97, NO. 1

Continued on next page ▶

The Modern Hospital

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READER OPINION

The Voluntary System Is a System

Sirs:

I am tempted to take issue with your May editorial, "Equilibrium."

It seems to me that here you have yielded to a popular misconception. There are certain words which we all tend, often justifiably, to equate with efficiency, such as centralization, uniformity and system, but I think it very easy to overrate their applicability to all circumstances. I would guess that this is particularly true for hospitals which, in functioning properly, must give a uniquely personal professional service of great complexity to sick people.

Your editorial begins by somewhat poking fun "in loving accents" at those who talk about "the American hospital system" or "our voluntary hospital system." You then go on to say that our voluntary hospital system is no system at all, and that in your opinion a system must have unity of purpose, method and result, and must be ordered or organized, "the parts coordinated so as to improve the productivity or excellence of the whole." You cite as systems those hospitals under central control.

My unabridged Webster's shows 13 definitions for the word system, some of which perhaps support your contention. But they are all admissible, and I rather like the following: "A regular orderly way of doing something; order; method; regularity." I believe that this is the definition of our hospital system. It's popular to be critical of our system and I hope we never lose the ability to see its faults, but coupled with this ability to criticize should be some understanding of the order that unquestionably exists. It is a perceived local need that creates a facility to care for sick people. Indeed, that need expressed through local action – organization and fund raising with patients cared for by an expert and highly trained profession – is to date the best assurance of a good hospital system. I would not ignore the value of examining the results attained. They can, of course, be improved by critical evaluation.

Looking at our voluntary or community hospital system we may say that there are too many small hospitals, that some of the population is not as close to a hospital as might be desirable, that some segments of the population do not have adequate access, that medical care varies in quality – but I think we can also say that a remarkably fine level of care is available country-wide, that all but a few in the population are close to a good hospital, and that progress in our time has been great. Our wide range of hospital ownership and operation gives opportunity to contrast different methods and to raise criticisms.

Thank goodness that a healthy drive toward criticism of present performance is a "built-in" trait of the medical profession and of the hospital field, and that there is ample opportunity for criticizing the system which has developed in this country.

(*Continued on Page* 8)

But no great service is done by so concentrating on criticism that the "order, method, regularity" in the system which I have mentioned is ignored. Where but in the free examination of alternatives can we find the true value and logic of local decision, granted that it has certain drawbacks? The Hill-Burton Act, for example, while requiring area-wide planning and review of local planning, is based primarily on the assumption that local determination coupled with adequate information will lead to wise decision.

You mention the Veterans Administration hospitals as an example of system, which you find lacking in voluntary hospitals. If I remember the Bradley-Hawley critique, it particularly concentrated on lack of wisdom in location of many of the hospitals in that system. The location of some of the hospitals apparently made no over-all sense, either in convenience of access or in maintenance of quality care.

You also mention the system of military hospitals. They, too, are not without criticism. It would not be difficult to question a system with independent subsystems serving each branch of the military. I recall instances of duplication which perhaps are now being corrected: for example, the Canal Zone with several United States service hospitals. Central authority in this system does not seem to ensure order.

Then you mention the system of state psychiatric hospitals. Many criticize the large size and poor location of such institutions generally, to say nothing of the quality of care they offer. Certainly from what I know of the municipal hospital system in New York City there is no evidence of results so much better from "order," "organization" and "coordination" through central control.

You mention the possibility of local devotion and dedication languishing under centralized authority, but imply that through a system such centralized authority will bring greater wisdom. I very much question this implication.

Let me say again that I am not defending our system of hospitals as faultless. I simply doubt that centralized authority — presumably required for a "system" — has demonstrated greater wisdom than the "order" in our present hospital establishment. The voluntary system with its admitted loopholes has gone a long way toward recognizing and correcting its faults, and does have a high degree of unity of purpose, method and result.

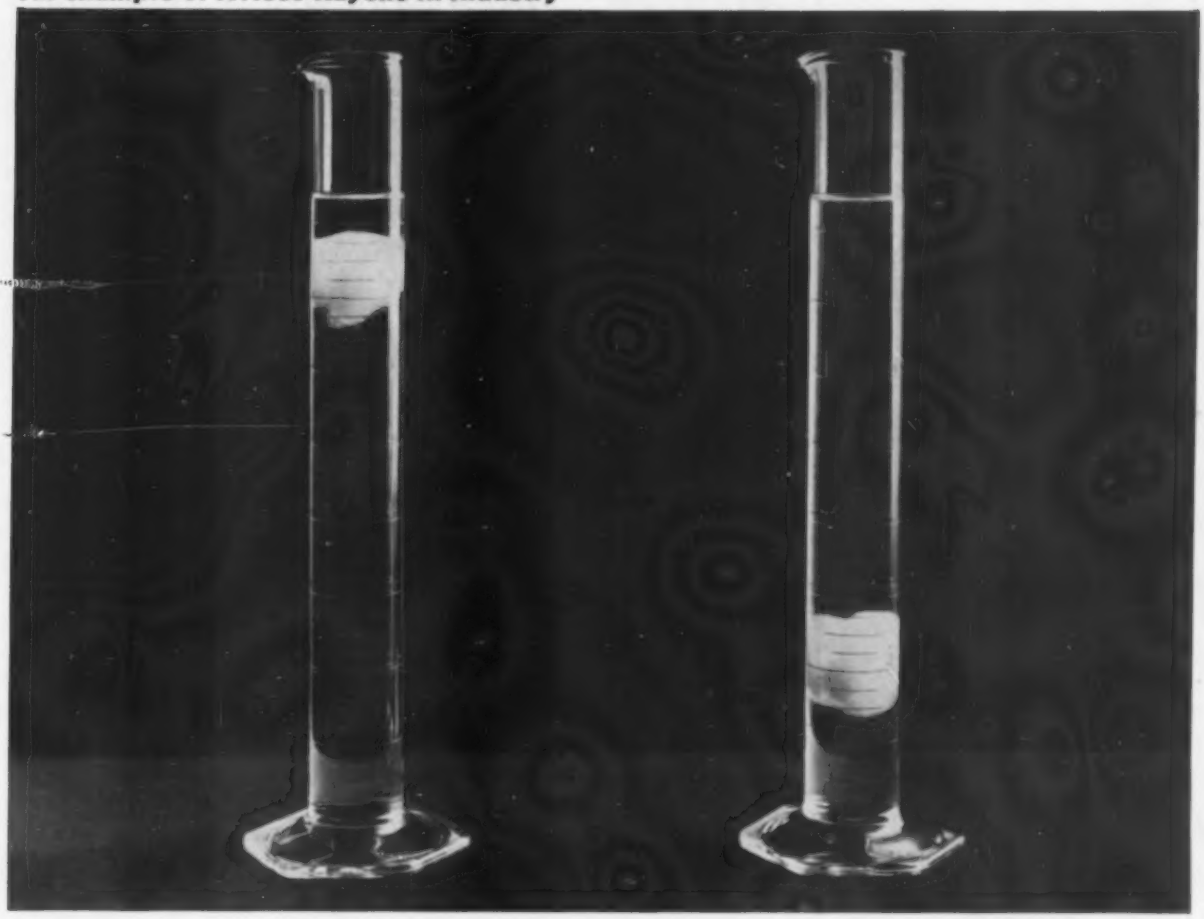
Above all, it has the great virtue of being self-critical — which a centralized authority can ill afford, or at best affords limitedly, if it is to perpetuate itself and to survive.

George Bugbee
President
Health Information Foundation
New York

Correction

On page 160 of the June issue, William J. Fowler was incorrectly identified as administrator of Ingalls Memorial Hospital, Harvey, Ill. Lester C. Mortrud is the administrator of the hospital. Mr. Fowler has been appointed assistant administrator.

An example of Avisco Rayons in Industry



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ROVING REPORTER

New Large Hospital Rises on 'Old Sod'

An underground electric train conveys hot food to the wards; patients use two-way radios to communicate with nurses; helicopters bring in emergency patients. These are some unusual features of Altnagelvin Hospital, Londonderry, Northern Ireland, reportedly the largest hospital built in the United Kingdom since 1945.

Situated near the second largest city in Northern Ireland, the Altnagelvin Hospital towers 150 feet from ground level and is a dominating feature of the skyline, according to W. L. Lucas, architect in charge of the building.

The hospital is designed as a complete unit for 391 patients, but can be expanded later to a capacity of 550 to 600 beds.

The main building consists of 12 floors in the ward wing and eight floors in the treatment wing. There is an outpatient wing attached to the main building at ground level.

The heart of the hospital is on the seventh floor of the treatment wing. This section is devoted entirely to the operating theaters suite. There are four theaters, each with its own anesthetic and recovery room and direct access to sterilizing and scrub rooms.

All service buildings of the recently opened hospital are hidden from view of the ward wing.

To avoid noise and smells, kitchens and stores were situated away from the main building. Food is transported to the wards by an electrically operated truck pulling heated trolleys through a tunnel to the main building.

Balconies at Altnagelvin Hospital overlook surrounding countryside.

'Neatness Counts' Was More Than Contest Rule

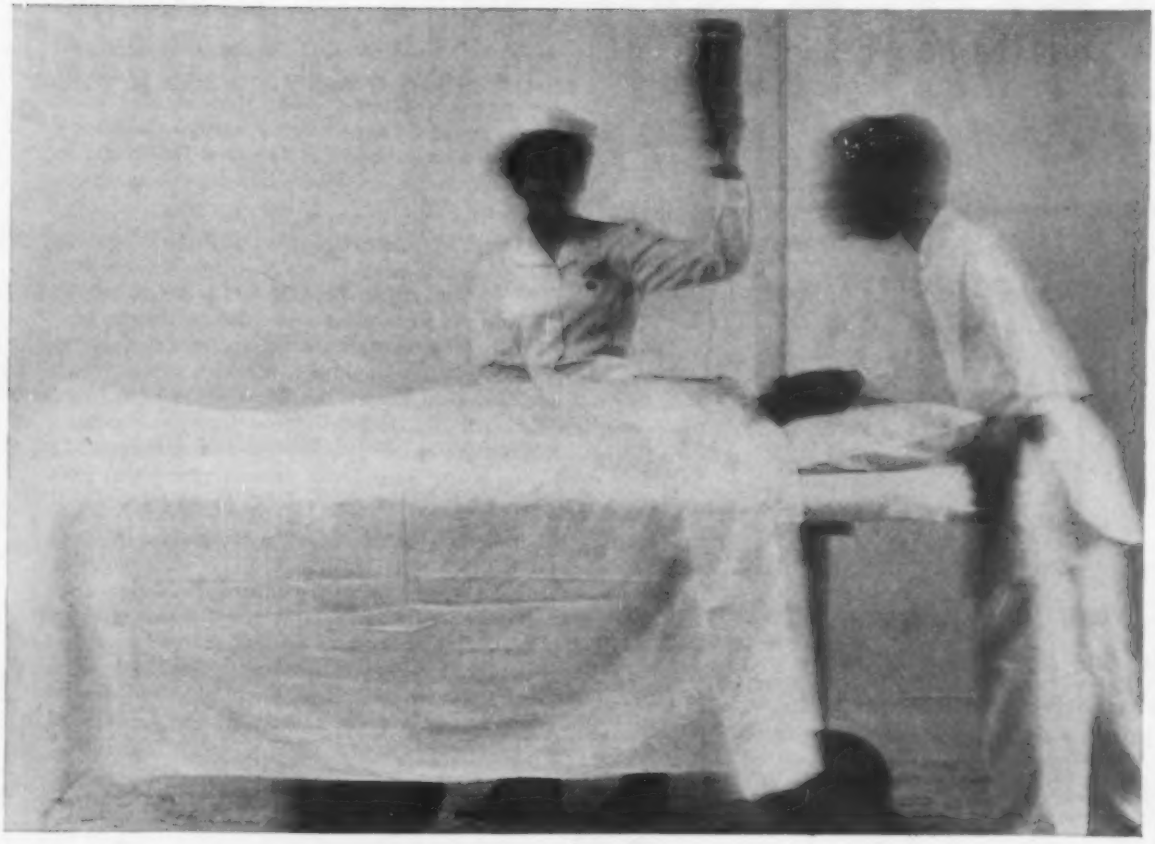
"Neatness counts" was more than a contest rule in the competition held recently at Research Hospital, Kansas City, Mo.; it was the theme of the good grooming campaign.

To point up the importance of a neat appearance, the nursing department of the hospital sponsored a contest among all groups of nursing personnel. Each of the displays, posters and models illustrating the essentials of good grooming in the hospital was used in the hospital display case for a week to publicize the campaign.

The winning entry, by the student practical nurses, is shown in the picture below.

Displays were judged on originality, theme achievement, group identification, and, of course, neatness.

when standard antishock measures fail



Indications and effects: Solu-Cortef is indicated when intense corticosteroid effect is necessary in various situations including acute adrenal cortical insufficiency, bilateral adrenalectomy, shock unresponsive to standard antishock therapy, acute hypersensitivity reactions, disseminated lupus erythematosus in relapse, and overwhelming infections with severe toxicity. *Administration and dosage:* Sterile Solu-Cortef may be administered intravenously or intramuscularly, the intravenous route being preferred in emergencies. The initial dose is 100 mg. or 250 mg., depending on the severity of the condition, injected over a period of one-half to one minute. This dose may be repeated at intervals of one, three, six and ten hours, depending on the response and clinical condition.

Precautions and contraindications: Careful management is required, especially during sustained therapy, to guard against untoward manifestations such as sodium retention, edema, excessive potassium loss, and negative nitrogen balance. Solu-Cortef is contraindicated (except for emergency replacement therapy in acute adrenal cortical insufficiency) in patients with tuberculosis, herpes simplex keratitis, chronic nephritis, acute psychosis, Cushing's syndrome, peptic ulcer, and predisposition to thrombophlebitis. Existence of congestive heart failure, hypertension, diabetes, osteoporosis, or chronic psychiatric disorders requires that Solu-Cortef be administered with extreme caution. In the presence of infection, the causative organism must be brought under control with appropriate antibiotics; otherwise Solu-Cortef should be discontinued.

Supplied: In 2 cc. Mix-O-Vial* containing 250 mg. or 100 mg. hydrocortisone (as hydrocortisone sodium succinate), and in 10 cc. vial containing 100 mg. hydrocortisone (as hydrocortisone sodium succinate) per vial.

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Sodium phosphate, exsiccated	8.73 mg.

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250 mg. Mix-O-Vial
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Sodium biphosphate	2 mg.
Sodium phosphate, exsiccated	21.83 mg.
Methylparaben	2.34 mg.
Propylparaben	0.27 mg.
Water for Injection	1.8 cc.

100 mg. Mix-O-Vial
Each Mix-O-Vial contains:

Hydrocortisone (as hydrocortisone sodium succinate)	100 mg.
Sodium biphosphate	0.8 mg.
Sodium phosphate, exsiccated	8.73 mg.
Methylparaben	2.34 mg.
Propylparaben	0.27 mg.
Water for Injection	1.8 cc.

In shock resulting from trauma, surgery, or overwhelming infection, Solu-Cortef* triggers vasopressor effects. As a result, patients often respond to Solu-Cortef when standard antishock measures have failed.

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Public Relations

Hospitals Must Teach Public Value of Ties With Blue Cross

By Gordon Davis

ONE of the dangerous misconceptions currently being insinuated into public thinking is the notion that there would be advantage in weakening hospital ties with Blue Cross.

Strangely, some hospital and Blue Cross people seem to assent to the idea. One might as well confess to a crime which hasn't occurred.

Gordon Davis

The specific proposal is that hospitals should not have majority representation on Blue Cross governing boards. Thus, it is implied, hospitals will no longer have sufficient power to – let's use the polite word – overcharge, thereby forcing Blue Cross rates to continue their spiral.

Step back and look at this one objectively for a moment. Isn't it another case of, "Have you stopped beating your wife?" In effect, the people are saying to the hospitals: "You have been stealing from the cash register. We're going to appoint new guardians."

How should you react? Should you demand exoneration from such insinuations, or should you meekly agree to the new guardians?

Clearly, to fail to take vigorous exception to measures designed to dilute hospital representation in Blue Cross – on grounds of principle if nothing else – is to accept a public relations stigma.

There is much more to the question than this, of course. Freed from hospital control, Blue Cross becomes just another insurance company. Yes, this would release both hospitals and Blue Cross from wearisome public responsibilities. It would also lead straight to state health insurance and a further concentration of power in an already top-heavy government.

At issue, too, is the almost childish assumption, widely supported by many who should know better and as widely exploited by many who do, that the pressures causing hospital costs to rise can be relieved by clamping on an iron lid.

From every standpoint, hospitals and Blue Cross should stand up and demand public recognition of the fact that their alliance is in the public interest. No other course is good conduct in the public relations sense. No other course conveys public conviction. No other course can dent the kind of specious reasoning that threatens our present system of health care.

If anything, the hospital-Blue Cross partnership has been too weak. In many instances neither party has met its obligations to the other, and this creates the appearance, if not the fact, of dissidence inviting outside intervention. Ironically, only the public will suffer if the attitude persists.

The fundamental principle for public relations guidance here has already been elaborated. As set forth in last month's column, hospitals exist to serve the people. Good public relations conduct does not permit retreat under any circumstances from public insistence to this effect.

Thus, there can be nothing sinister in hospital relationships with Blue Cross or with any other agency. Critics who imply otherwise should be properly spanked, perhaps even publicly. In standing up for their own rights, hospitals in effect are standing up for the right of the common man to be well served. ■

There's no fine print in Onan's pricing policy!

'Strip-downs' and 'price-adders' are getting out of hand in the electric plant industry. There have always been a few who have sold strictly on price, and of course, got the price down by stripping equipment of essential components.

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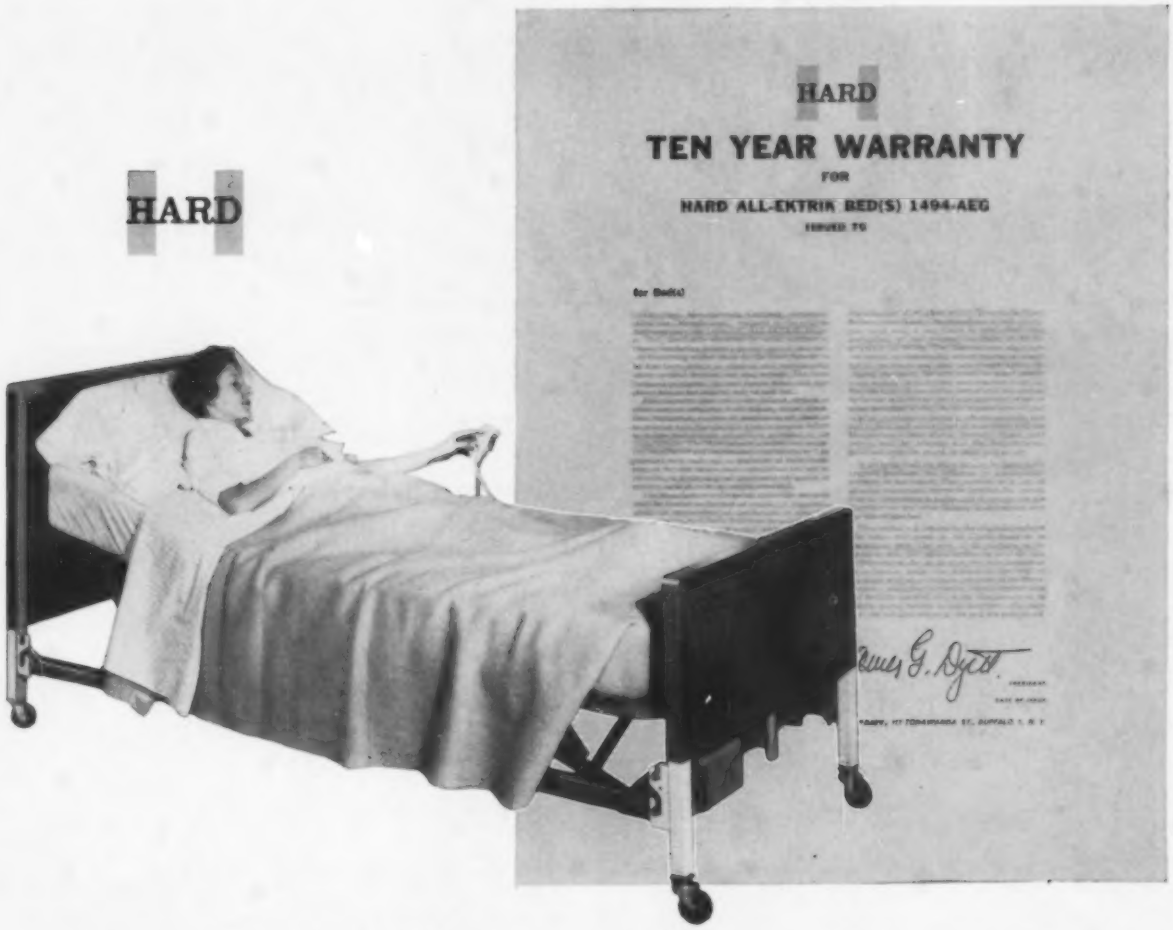

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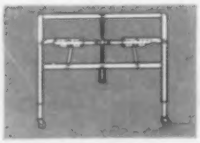

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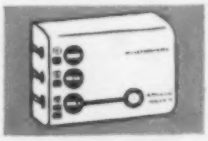

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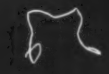

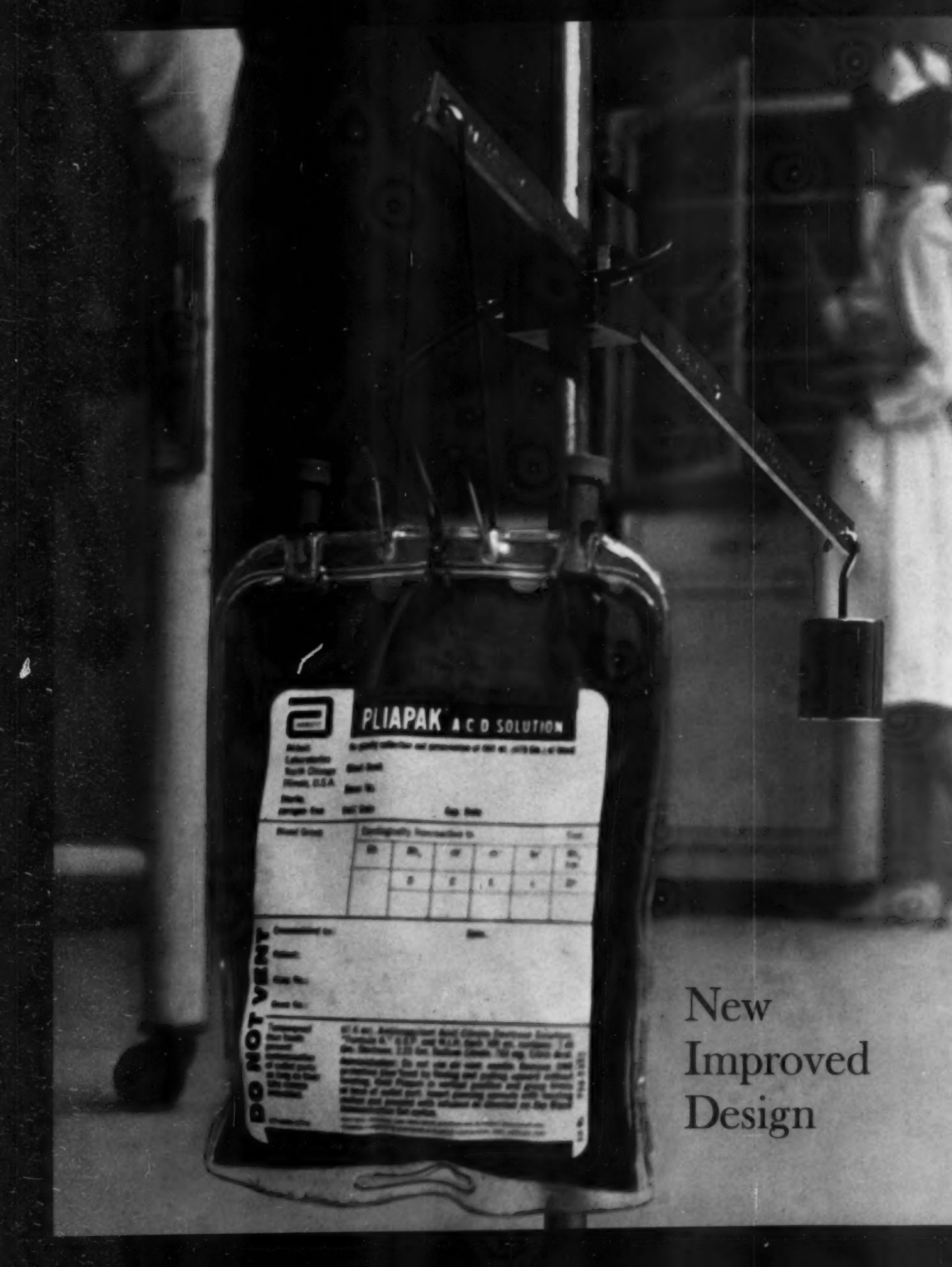
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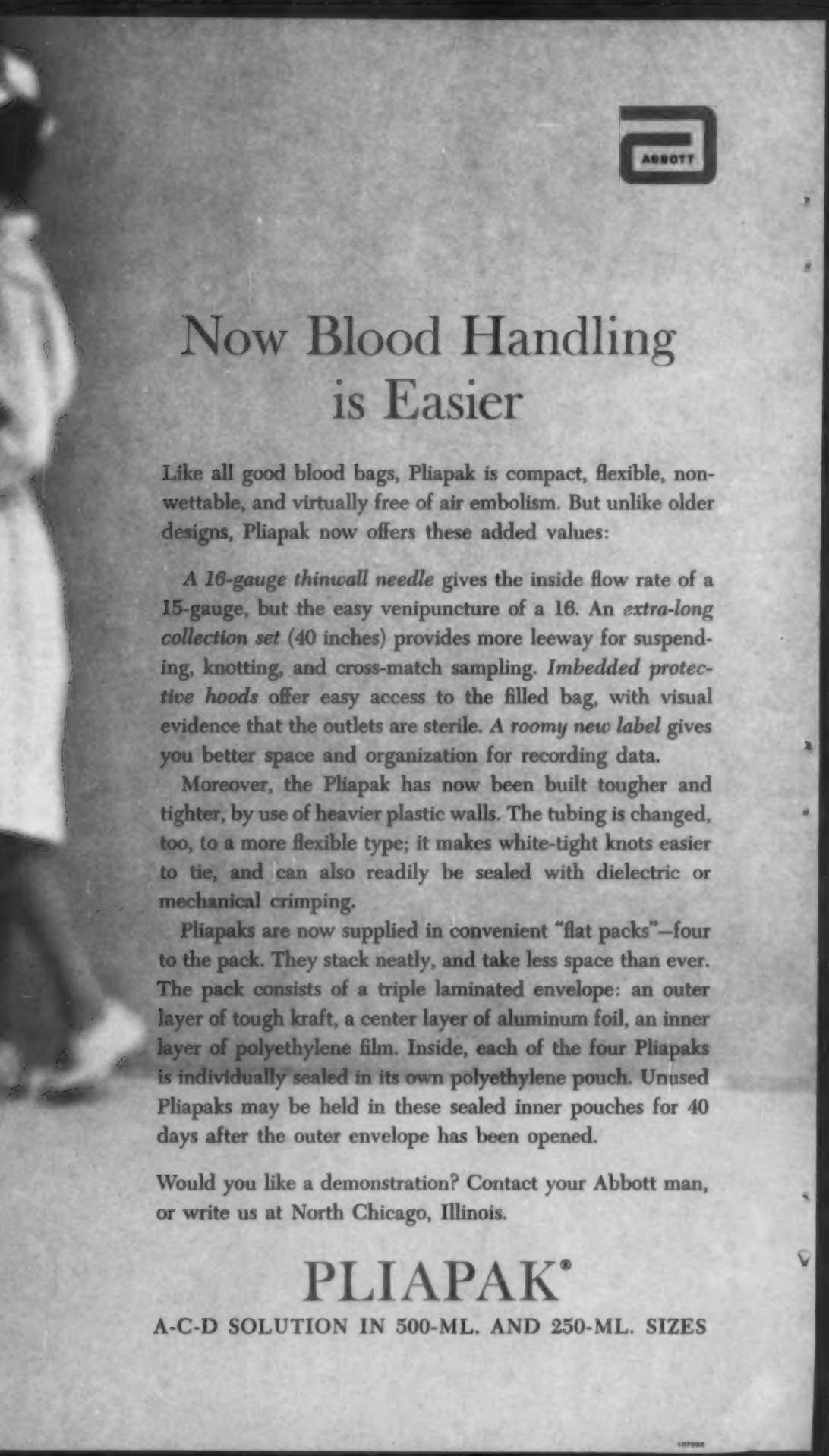

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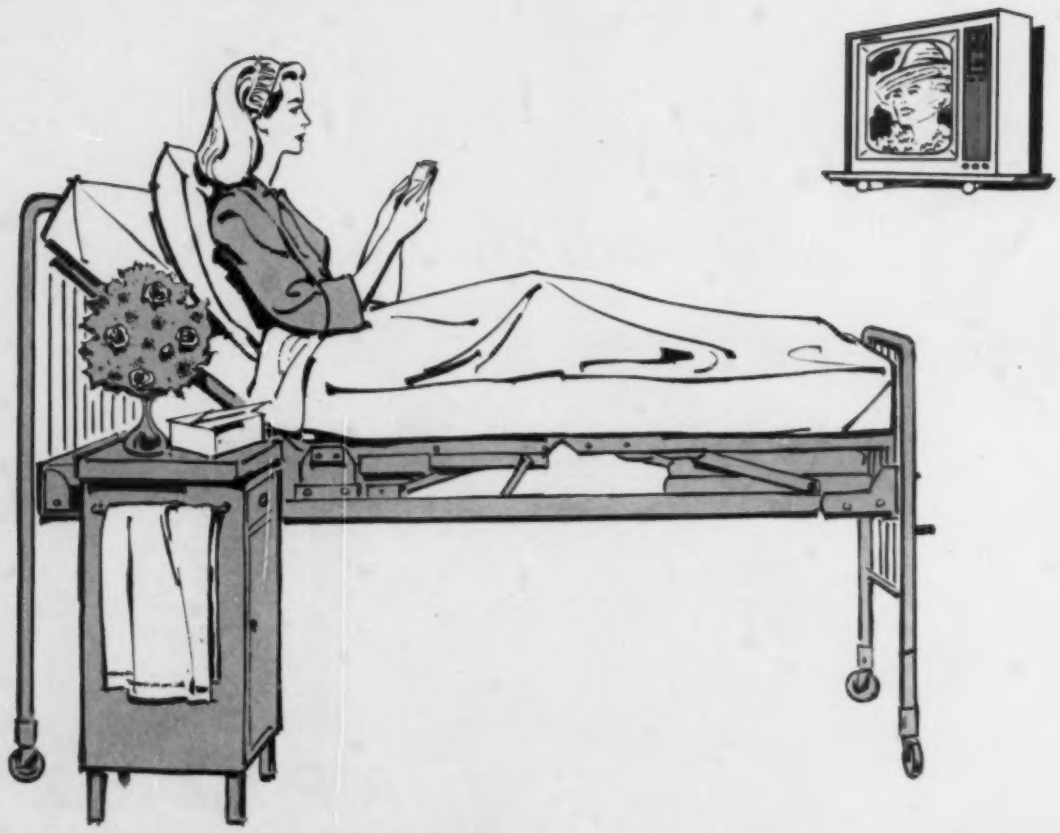

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2. **Master-Tenna® System,** custom-designed to pull in best possible picture and sound for your particular area. Concealed lines run to room outlets. Closed circuit TV for lobby surveillance, private telecasts.
3. **RCA Factory Service** begins with complete installation and ends all service worries from then on. You get unlimited service by RCA's own technicians, through local RCA Service Company branches in most major markets.

Every hospital—*your* hospital—searches for ideas to benefit patients and at the same time clearly add to hospital income. Your best answer yet: the RCA Hospital Television Lease Plan! Send the coupon for free and full information...right now!

RCA VICTOR HOSPITAL TV—174 sq. in. viewable picture, Full-Picture 19-inch tube (overall diagonal). Optional swivel wall bracket saves floor space. Metal cabinet finished in ivory. Heavy-duty power cord.

Specifications subject to change without notice.

RCA Service Company, Hospital TV, Commercial Products Sales,
Box MH-1, Cherry Hill, Camden 8, N. J.

Please send me additional information about the RCA Hospital TV Lease Plan.

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Hospital_____ Phone_____

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RCA®

The Most Trusted Name in Television

RADIO CORPORATION OF AMERICA

ALL

AMSCO equipped Solution Rooms have one "Common Factor"...

they save hospitals thousands of dollars every year

Of the many procedure changes possible in modern hospitals, *none will save more dollars annually* than the conversion to hospital-made solutions.

Hundreds of hospitals . . . seeking to cut costs while maintaining rigidly high standards . . . have turned to Amsco for objective recommendations concerning the proper "Solutions Program" *for their particular needs.*

It is well known that 75% of hospital solutions are used for external or irrigating purposes. The balance of course, are lifesaving parenterals. It's equally well known by hospitals currently benefiting from an Amsco designed and equipped Solution Preparation Room that these same External or Surgical Solutions... and many Parenterals .... can be made at one-quarter the cost of commercial solutions.

Many hospitals take this practical approach:

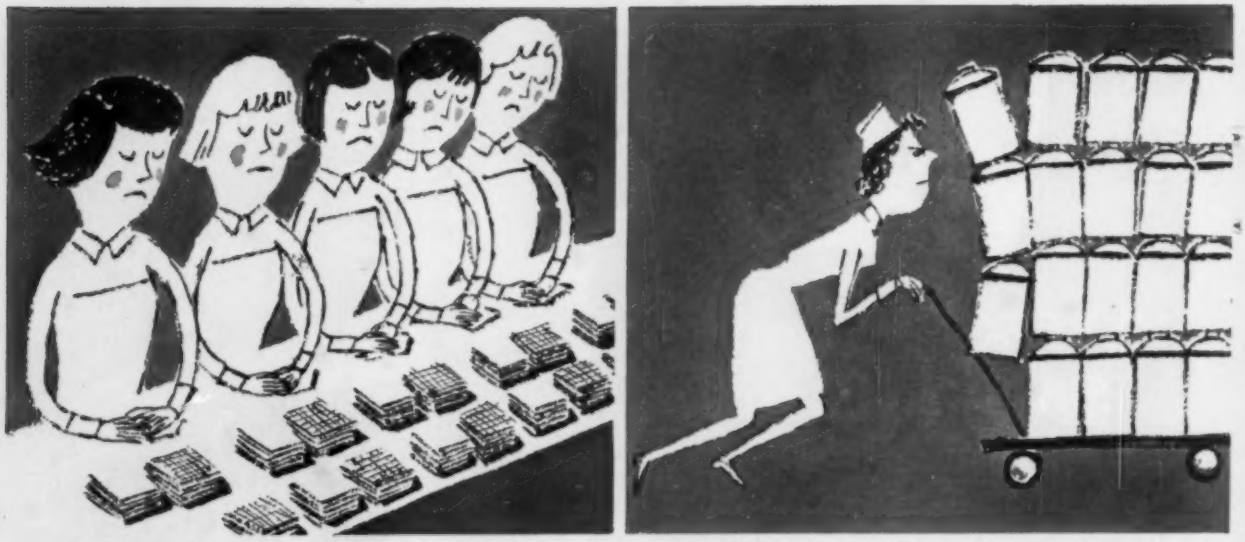
- **They produce their own External Solutions and many Parenterals in an Amsco equipped Solution Preparation Room located in the Central Service Department or Pharmacy. Critical Electrolyte Solutions, Blood Transfusing Plastic Bags, Bottles and Sets, and Disposable Solution Administration Sets are purchased from AMSCO LABORATORIES . . . a division of the American Sterilizer Company.**
- **Others produce only External Solutions . . . depending upon AMSCO LABORATORIES for all their Parenterals, Disposable Sets, etc.**

Why not ask your Amsco man to discuss an OBJECTIVE, correctly-balanced "Solution Program" for your hospital? It will be based solely on the specific solution needs, available floor space and your existing equipment. The results of our studied recommendations will involve minimum capital investment . . . and a significant decrease in your annual solutions costs.

Write for our 32-page brochure "Sterile Fluids for the Hospital"— MC-513.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

World's largest designer and manufacturer of Sterilizers, Operating Tables, Lights, and related technical equipment for hospitals



Don't waste time with rolling your own dressings . . . . . packing each one into cans for sterilization . . . . . .

Now–sterile abdominal pad in S-E Pack...for complete sterility all the way to the wound

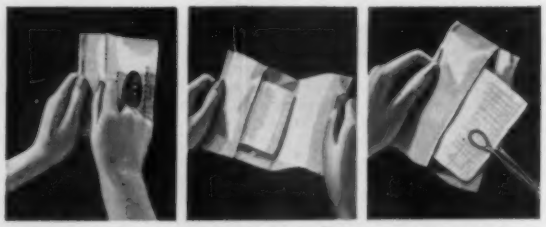
(A LOW-COST, COMMON-SENSE DEFENSE AGAINST STAPH INFECTIONS)

In one simple motion Curity S-E Pack opens (without scissors or string) and applies a totally aseptic pad to the patient—never touching torn, unsterile edges.

The S-E Pack is a significant advance in aseptic dressing technique. And now it's available in an abdominal pad.

The new S-E Pack offers the ultimate in ease of application. It enables you to deliver a totally sterile dressing to the wound—without fumbling, dropping or contaminating the pad with fingers or pack edges.

Another distinct benefit of the S-E Pack is its economy. A saving of time and action, plus fewer dressings. You can use one pack instead of a stack.

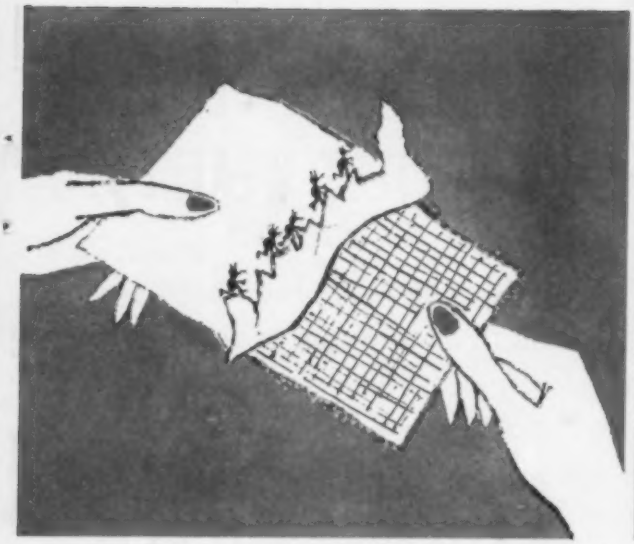


1. Simply peel back one flap and dressing is ready to apply. 2. Dressing is tucked in pocket . . . easy to reach with one hand. 3. Other hand is free to apply sterile dressing to the wound.

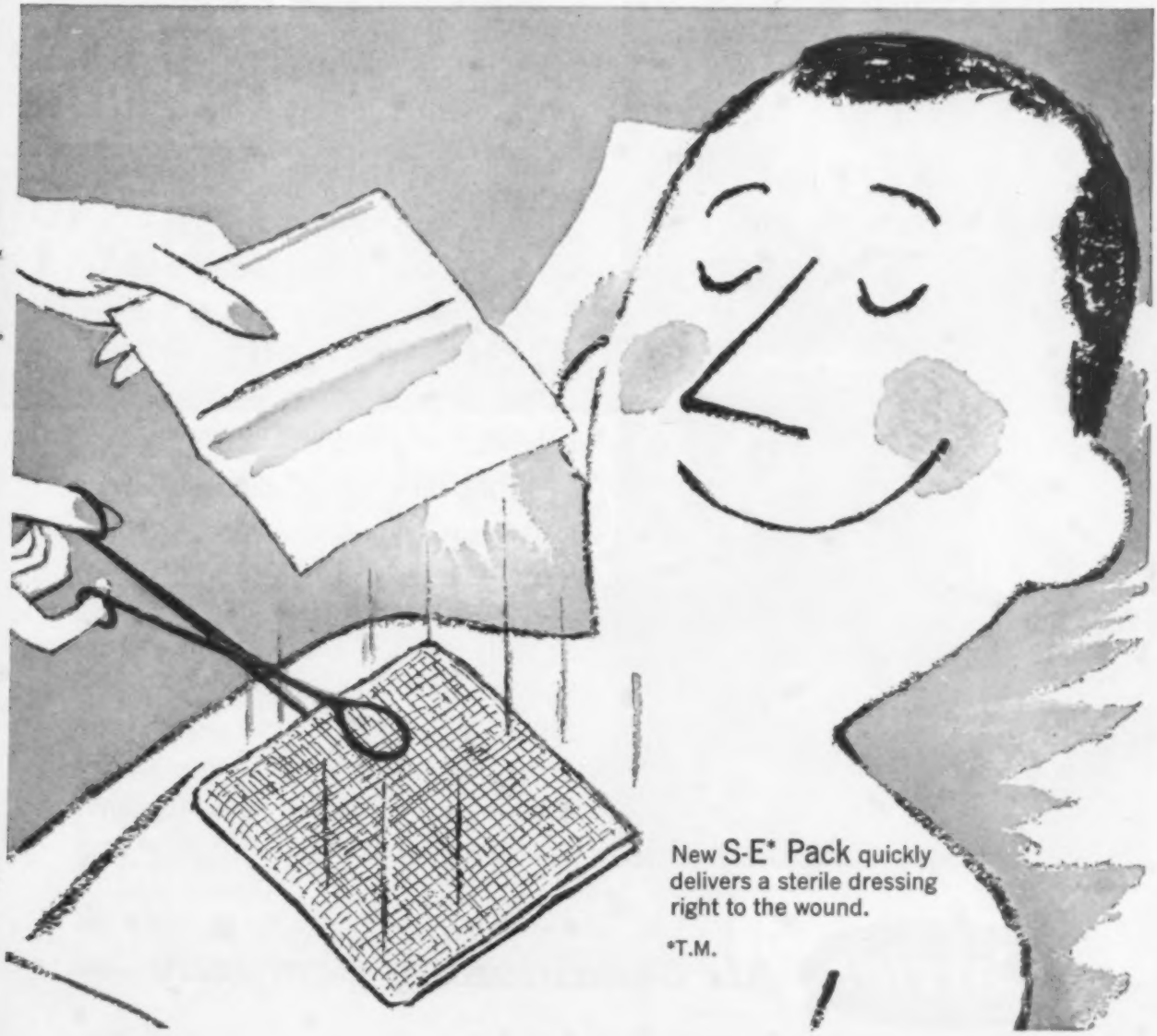
Sterile abdominal pads come in three sizes: 9" x 5" —7½" x 8"—10" x 8". Cover sponges and gauze sponges are also available in S-E Pack, in a variety of sizes. Call your Curity representative for complete details about the improved asepsis and outstanding economy of **S-E Pack.**

Curity®

THE KENDALL COMPANY
BAUER & BLACK DIVISION



. . . . prepacks that contaminate dressings when removed . . . . . or ones that take 3 hands to open



New S-E* Pack quickly delivers a sterile dressing right to the wound.

*T.M.

At the Grady Hospital, Atlanta, Ga.

THIRTEEN CARRIER AUTOMATIC ICE MACHINES DELIVER "CERTIFIED CAPACITY" EVEN IN THE HOTTEST WEATHER!

Model 26H3: capacity, 214 pounds of cubes daily at 60° water, 70° air.

No one ever worries about the ice supply at the Grady Hospital. Even when the temperature soars, they know how much production they can count on from their Carrier Automatic Ice Machines. The reason? Each machine is backed by Carrier's exclusive "Certified Capacity."

What is "Certified Capacity"? It's your assurance—*in writing*—that a Carrier unit will deliver a specified amount of ice according to the exact air and water temperatures in your locality. With Carrier units, you never have to worry about your ice supply—even in the hottest weather. You know how much ice to expect any day of the year. Carrier—*and only Carrier*—assures you of all the ice you need . . . when you need it . . . regardless of season.

In all, there are 16 different Carrier models—in four types: cubes, crushed, flakes and chips. Compared with delivered ice, they can cut your ice bills as much as 80%. In fact, you can easily pay for your machine out of savings. For more information, call your Carrier dealer, listed in the Yellow Pages under "Ice Making Equipment." Or write Carrier Air Conditioning Company, Syracuse 1, New York.

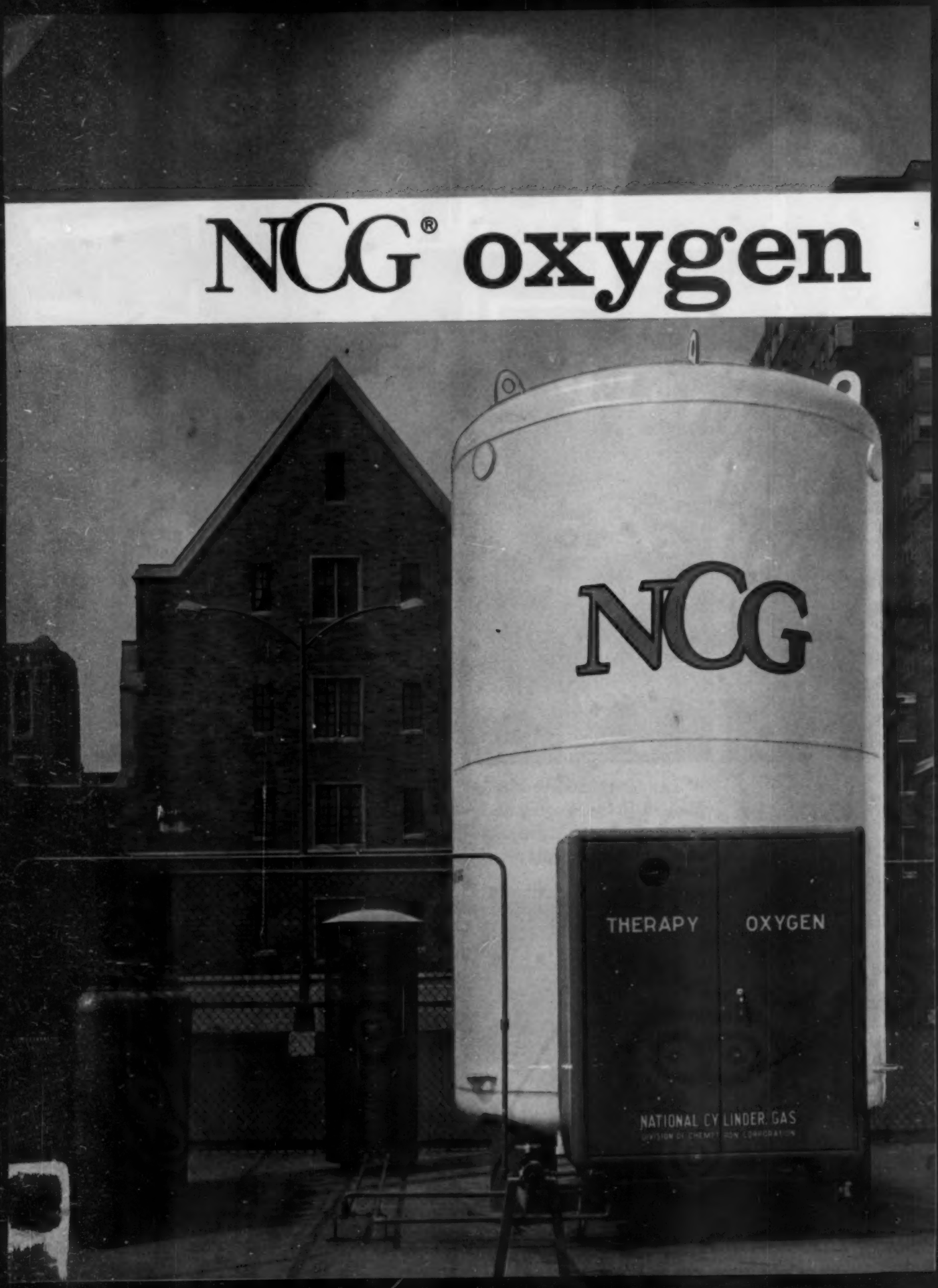
Carrier Air Conditioning Company

A completely modern surgical wing now nearing completion at world-famous Michael Reese Hospital and Medical Center, Chicago. Operating room nurses helped design all 22 surgical suites in this new four-story pavilion, where every measure has been taken for maximum patient care and surgical teamwork.

If you like the challenge of working in Chicago's largest private hospital (937 beds) . . . if you enjoy serving alongside distinguished surgeons and medical research scientists, there's a place for you now on the O.R. Staff of Michael Reese Hospital. Applications for Operating Room Supervisors, Head Nurses and Staff Nurses are being accepted for immediate openings.

For more information write

Director of Nursing
Michael Reese Hospital and Medical Center
29th Street and S. Ellis Avenue
Chicago 16, Illinois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THERAPY OXYGEN
NATIONAL CYLINDER GAS

at work...

The use of oxygen in hospitals, clinics, medical centers and nursing homes has grown at a remarkable rate. With this growth, storage facilities and equipment have been improved to assure ample supply at all times.

NCG service extends beyond the supply of oxygen and the most effective equipment for its use. It includes the development of new apparatus to improve the *methods* of its administration. NCG not only keeps abreast of the field, but collaborates with leading inhalation therapists and physicians in their research.

Whether your hospital is large or small, NCG can provide the oxygen system that will best serve the requirements of your institution. A vast network of plants and sales offices are ready to serve you quickly at all times. NATIONAL CYLINDER GAS DIVISION OF CHEMETRON CORPORATION, Dept. M-4G, 840 N. Michigan Ave., Chicago 11, Illinois.

NCG®

NATIONAL CYLINDER GAS

Division of CHEMETRON *Corporation*

IN SURGERY. *Monaghan Anesthalung*, the new and compact assistor-controller, attaches easily to and becomes a vital part of any gas machine. It delivers an accurate preset volume of gas to the patient at any desired rate. Rate-volume-pressure can be changed as required . . . volume controlled-pressure limited, or pressure controlled-volume limited.

IN INTENSIVE CARE. NCG Nursing and Service Unit permits nurse to serve four patients simultaneously. Working at each patient's head, necessary apparatus and supply lines are within easy reach. When not in use, the ceiling mounted unit telescopes up and out of the way providing for free flow of traffic and easy cleaning.

IN PEDIATRICS. New croup tent, effectively ice-cooled, supplies high humidity aerosol therapy with or without detergents; nebulization therapy with antibiotics; oxygen therapy with normal humidity. Enclosure sleeve seals unit comfortably about patient. Tent can be folded for easy handling and storage.

IN EMERGENCY. The "First-In" portable resuscitator moves quickly to the emergency. It is lightweight, rugged, effective and safe. It contains the famous *Handy*® resuscitator that automatically breathes the patient when the breath of life is gone. It may be used as a resuscitator, an aspirator or an inhalator.

*Trademark

NEW PATIENT SAFETY:

HERE ARE THE FACTS ON THE NEW, HIGH-FILTRATION

SCOTCH® SURGICAL MASK

BRAND

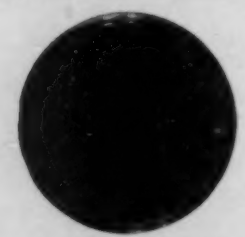
HOW DOES THE "SCOTCH" BRAND SURGICAL MASK COMPARE IN FILTERING EFFICIENCY WITH GAUZE MASKS?

In hundreds of controlled comparative tests (utilizing both in-use and mechanical sampling methods ... both new and used masks ... both brief and sustained testing periods) the "SCOTCH" Surgical Mask averaged up to 35 times more effective than gauze in filtering out airborne bacteria.

TYPICAL TEST RESULT: (masked subjects, 2 minute test period)

1. "SCOTCH" SURGICAL MASK. Test shows development of average of only 3 colonies. "SCOTCH" Surgical Mask removed average of 99.4% of airborne organisms.

2. STANDARD GAUZE MASK. Average of 105 colonies developed. Test series indicated gauze mask removed average of only 76.4% of organisms.



3. NO MASK. As a control, series of plates were exposed for two minutes to unmasked subjects. Average growth was 445 colonies.

WHY IS THE DESIGN AND CONSTRUCTION OF THE "SCOTCH" SURGICAL MASK SO EFFICIENT?

The "SCOTCH" Surgical Mask is molded of a new stabilized-porosity synthetic fabric with an unusually high filtration capacity. Unlike soft, woven fabrics such as gauze, its built-in porosity is permanent. There is little or no variation from mask to mask and no radical loss of efficiency due to compression, matting, or wetting during use.

HOW DOES THE CONTOURED SHAPE OF THE MASK INCREASE ITS FILTERING EFFICIENCY?

Because it is held away from the mouth and nostrils, virtually the entire inner surface of the "SCOTCH" Surgical Mask acts as a filter. Exhaled moisture droplets are not propelled through a small area, but are dissipated at low velocity within the mask.

MUST THE "SCOTCH" SURGICAL MASK BE CHANGED DURING PROLONGED PROCEDURES?

Rarely. Whereas gauze masks rapidly lose efficiency due to wetting and must be changed frequently, the "SCOTCH" Surgical Mask shows little or no drop-off in filtering effectiveness in extended use.

HOW IS LEAKAGE AROUND THE MASK EDGES CONTROLLED?

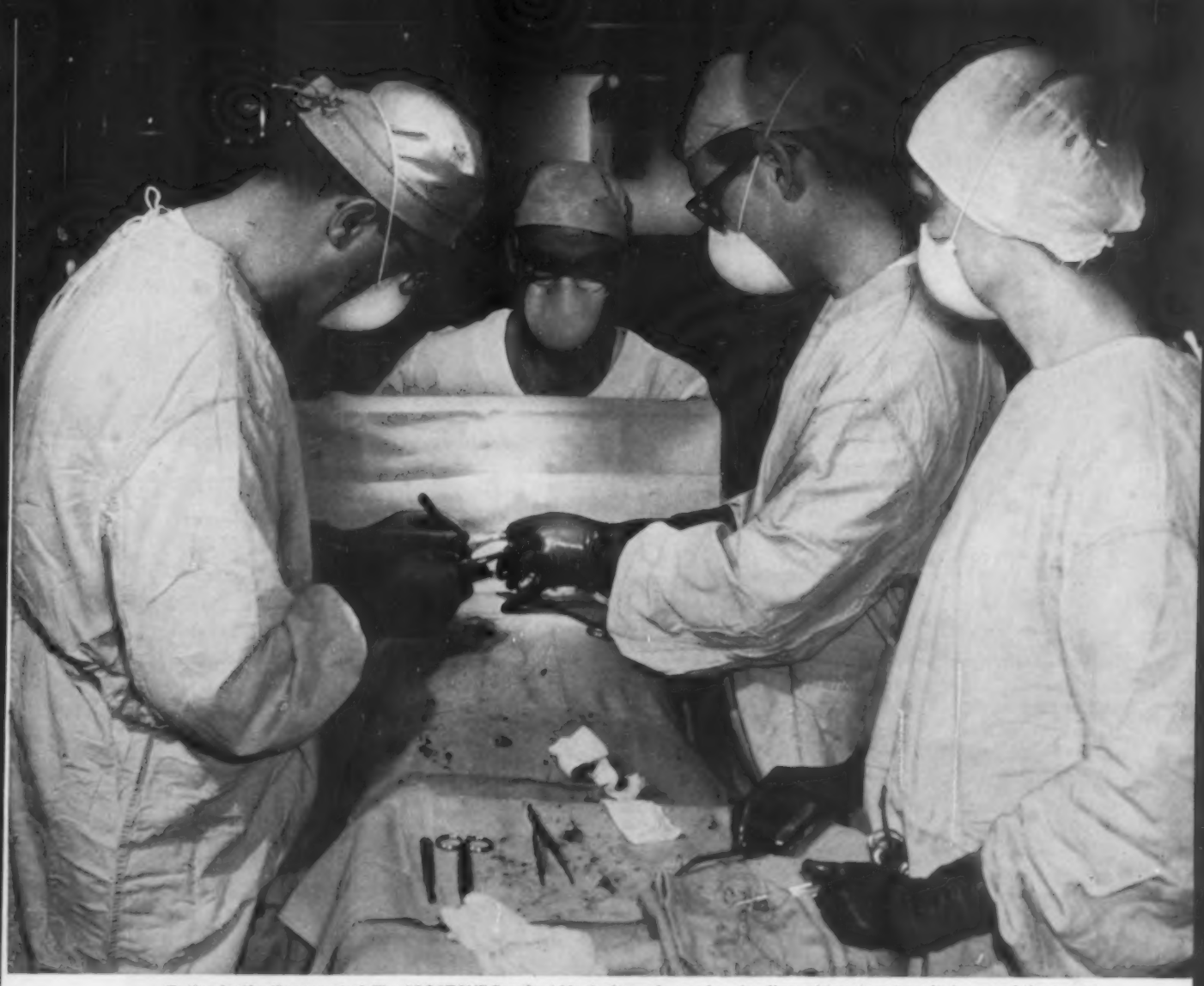
The adjustable nose piece, contour shape and elastic band of the "SCOTCH" Surgical Mask provide a close fit that minimizes air leakage. Fogging of glasses is almost totally eliminated.

DOES THE MASK'S HIGH FILTRATION MAKE BREATHING DIFFICULT?

Not at all. Because of its large effective filtering area, breathing is actually easy. There is no significant CO_2 build-up within the mask. Speech is not muffled.

WHAT ABOUT COMFORT?

The "SCOTCH" Surgical Mask has been called "the most comfortable yet." It is lightweight (9 masks weigh only one ounce). Measured skin temperatures have proved 1° cooler than inside gauze masks. Vision is not obstructed. Elastic band holds mask in correct position without slipping or binding. There are no strings to tie or adjust.



Enthusiastically accepted. The "SCOTCH" Surgical Mask shown in use in a leading midwestern hospital—one of the many institutions that have already standardized on this high-filtration disposable mask.

IS THE "SCOTCH" SURGICAL MASK EXPENSIVE TO USE?

No. An independent six-month cost study at a leading hospital showed virtually identical over-all costs whether the "SCOTCH" Surgical Mask or gauze masks were used. "SCOTCH" Surgical Masks cost approximately 9 cents each at quantity prices . . . eliminate all inspection, laundry and re-sterilization costs.

CAN THE MASK BE AUTOCLAVED?

Yes. While this mask is designed and priced to be fully disposable, it may be steam autoclaved with no loss of filtering efficiency.

HOW CAN YOU TRY THE "SCOTCH" SURGICAL MASK IN YOUR HOSPITAL?

Your surgical supply dealer can fill your trial order promptly—box of 50 masks, only $6.00; case of 10 boxes, $54.00†. Or, for free samples and additional literature, contact your 3M Sales Representative or write to 3M Company, Dept. NAN-71, 900 Bush Avenue, St. Paul 6, Minnesota.

†PRICES SUBJECT TO CHANGE WITHOUT NOTICE.

REG. U. S. PAT. OFF.

SCOTCH BRAND SURGICAL MASK*

NO. 8300

MINNESOTA MINING AND MANUFACTURING COMPANY

...WHERE RESEARCH IS THE KEY TO TOMORROW

3M

*PATENT PENDING

"SCOTCH" is a registered trademark of 3M Co.

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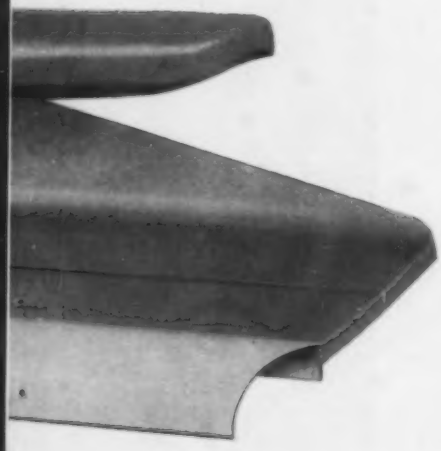
DYNA★PAK®
Laundry Press

the surest way to spoil your employees

. . . and yourself!



Operators will be spoiled by the DYNA-PAK'S fast, smooth operation. It's quiet, too — a real pleasure to work on. (We have to caution you though — if you have several press operators you'll probably have to buy each of them a DYNA-PAK Unit).

Maintenance Engineers will be spoiled by the DYNA-PAK'S unusually simple design. No toggles, cams, levers or pivots to lubricate, adjust or replace. Only nine lubricating points (7 grease, 2 oil). And, up to 400 fewer parts than any other laundry press now on the market.

Plant Managers and foremen will be spoiled by the new, higher standards they get in production and quality of work. DYNA-PAK'S ease of operation keeps employee morale high, makes the training of new operators a snap.

You Too, will be spoiled by the way DYNA-PAK out-produces every other press you've ever seen. No other laundry press has such instant response, such smooth, quiet, shock-free action. No other press can match it for fine quality finishing. No other press will make so much money for you.

Don't wait. You owe it to yourself to try a DYNA-PAK soon. Ask your nearby American representative to show you one in action or mail coupon for Catalog AK 230-002.

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American Laundry Machinery Industries
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American Laundry Machinery Industries ALM-805
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Send Catalog AK 230-002 on American's DYNA-PAK Laundry Press.

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New addition to Pittsburgh Children's Hospital.
Architect: *Alfred D. Reid & Associates;* Electrical Engineer: *J. G. Stauffer.*

Award-winning hospital design adapts Day-Brite lighting to area function

The new addition to the Pittsburgh Children's Hospital has been hailed as "an outstanding example of the use of structural steel and a unique, attractive solution to a hospital's functional problem."

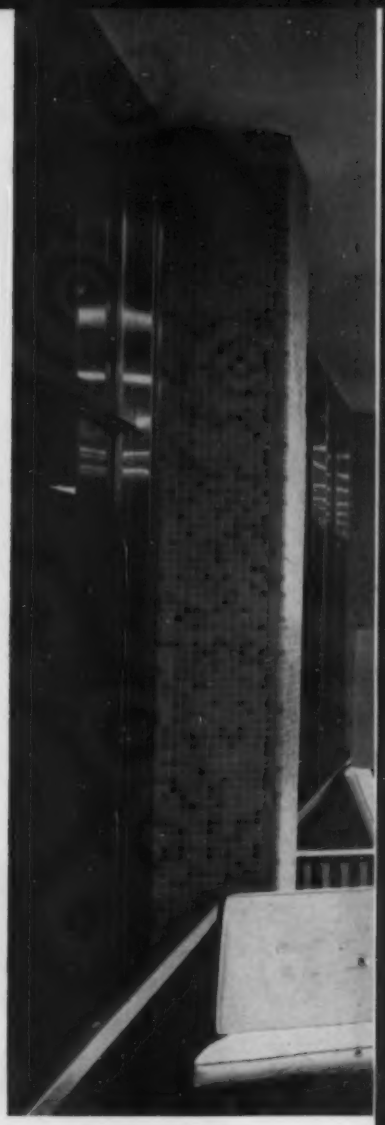
Creating a cheerful, pleasant atmosphere that would lift spirits of patients, visitors and employees called for generally high level, softly diffused illumination throughout the hospital. Day-Brite recessed TROFFERS and MOBILEX® with distinctive CLEARTEX® plastic diffusers (to minimize glare prismatically) were specified. Exact footcandle levels and ceiling plans were tailored to the needs of each area.

Whether you're lighting a hospital, store, school or factory, you can always depend on Day-Brite's over-all excellence and wide variety of fixture designs to meet every lighting situation with award-winning results. Contact your Day-Brite representative or write *Day-Brite Lighting, Inc., St. Louis, Mo., and Santa Clara, Calif. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ont.*

Write for FREE **Manual of Hospital Lighting:** Day-Brite Lighting, Inc., 6260 N. Broadway, St. Louis 15, Mo.

DAY-BRITE

NATION'S LARGEST MANUFACTURER OF
COMMERCIAL AND INDUSTRIAL LIGHTING EQUIPMENT



Horizontal arrangement of Day-Brite TROFFERS makes waiting area in out-patient clinic look wider, more spacious. Incandescent UNI-FRAME® lens boxes highlight registration desk.

Day-Brite MOBILEX® maintain laboratories at 75 to 100 footcandles to facilitate critical visual analyses.

Informal dining room, cheerfully lighted by Day-Brite TROFFERS, typifies tone of the entire hospital.

engine power
BY CATERPILLAR

WHICH HOSPITAL NEEDS CATERPILLAR STANDBY POWER?

One hospital is the City of Hope. The other is the 99-bed Annie M. Warner General Hospital, Gettysburg, Pa.

Both need the protection of Caterpillar emergency power sets. And *both have it.* If there's the remotest chance of utility power failure it is needed . . . and the kind of standby you need is the kind a Caterpillar Diesel or Natural Gas Electric Set provides.

A Cat Electric Set gives you power whenever you need it. You can install Cat Standby Power to cover emergency areas —O.R. suites, O.B. and Maternity, X-ray labs, and places where sudden or prolonged darkness would confuse or alarm patients. Or you can have complete protection to let your entire facility continue without electrical shortage anywhere. You can decide the amount of power you *must* have and build from there.

A Cat Standby Set relieves you from concern over power failure. Equipped with automatic start-stop controls, and properly installed, it takes over the load within as little as six seconds after outside power fails. It produces the electricity you need until outside power returns. It runs hours or days—as long as you need.

A Cat Electric Set seldom needs attention, except for occasional routine test runs; and it operates on safe, dependable diesel fuel, or can be equipped to burn equally safe and dependable natural gas.

If your hospital has old, inadequate or unreliable standby power, investigate Caterpillar Electric Sets now. Your Caterpillar Dealer has new units with many new features and their cost is extremely attractive. Call your Caterpillar Dealer for an analysis of your needs and a recommendation to give you, your staff and patients complete protection.

Caterpillar power means dependable power. If you like, write for a copy of "Guide Book for Emergency Power," 24 pages of factual data on emergency power.

CATERPILLAR

Caterpillar and Cat are Registered Trademarks of Caterpillar Tractor Co.

Engine Division, Caterpillar Tractor Co., Peoria, Illinois, U.S.A.

At City of Hope Medical Center, Duarte, California, a Cat Electric Set currently furnishes standby power for operating theater, corridors, X-ray and various patient-care areas. Installation will be expanded to protect many additional functions. All Cat Electric Sets are suitable for multiple operation for larger KW loads.

Cat Diesel Electric Set in Annie M. Warner General Hospital, Gettysburg, Pa., furnishes power for the entire electrical needs of the hospital. Note simplicity of installation, with no massive supporting work needed. Engine is quiet. Cat Electric Sets are available up to 450 KW as diesel and 375 KW as natural gas units.

PHARMASEAL LABORATORIES · GLENDALE, CALIFORNIA

* Trade mark

CUT DRAIN ON THE BLOOD BANK

Adrenosem®*

SALICYLATE

(Brand of carbazochrome salicylate)

Adrenosem helps conserve the patient's own blood. Adrenosem is accepted pre-op medication because it reduces the need for transfusion.

Adrenosem controls excessive capillary bleeding by decreasing capillary permeability while promoting the retraction of the severed capillary ends. Adrenosem's control of bleeding results in a clearer operative field. Reduction of postoperative ooze and seepage results in fewer calls on the nursing staff.

The safety and effectiveness of Adrenosem are proved by the administration of over 17 million doses in thousands of hospitals during the past 7 years. *There are no contraindications to Adrenosem at recommended dosage levels.*

SUPPLIED: *For I.M. injection only*—Ampuls: 5 mg., 1 cc., packages of 5 and 100; 10 mg., 2 cc., packages of 5. *For oral administration*—Syrup: 2.5 mg. per 5 cc. (1 tsp.), bottles of 4 oz. Tablets: 1 mg. (s.c. orange), bottles of 50, and 2.5 mg. (s.c. yellow), bottles of 50.

WRITE FOR DETAILED LITERATURE AND DOSAGE INFORMATION.

*U.S. Pat. Nos. 2581850; 2506294

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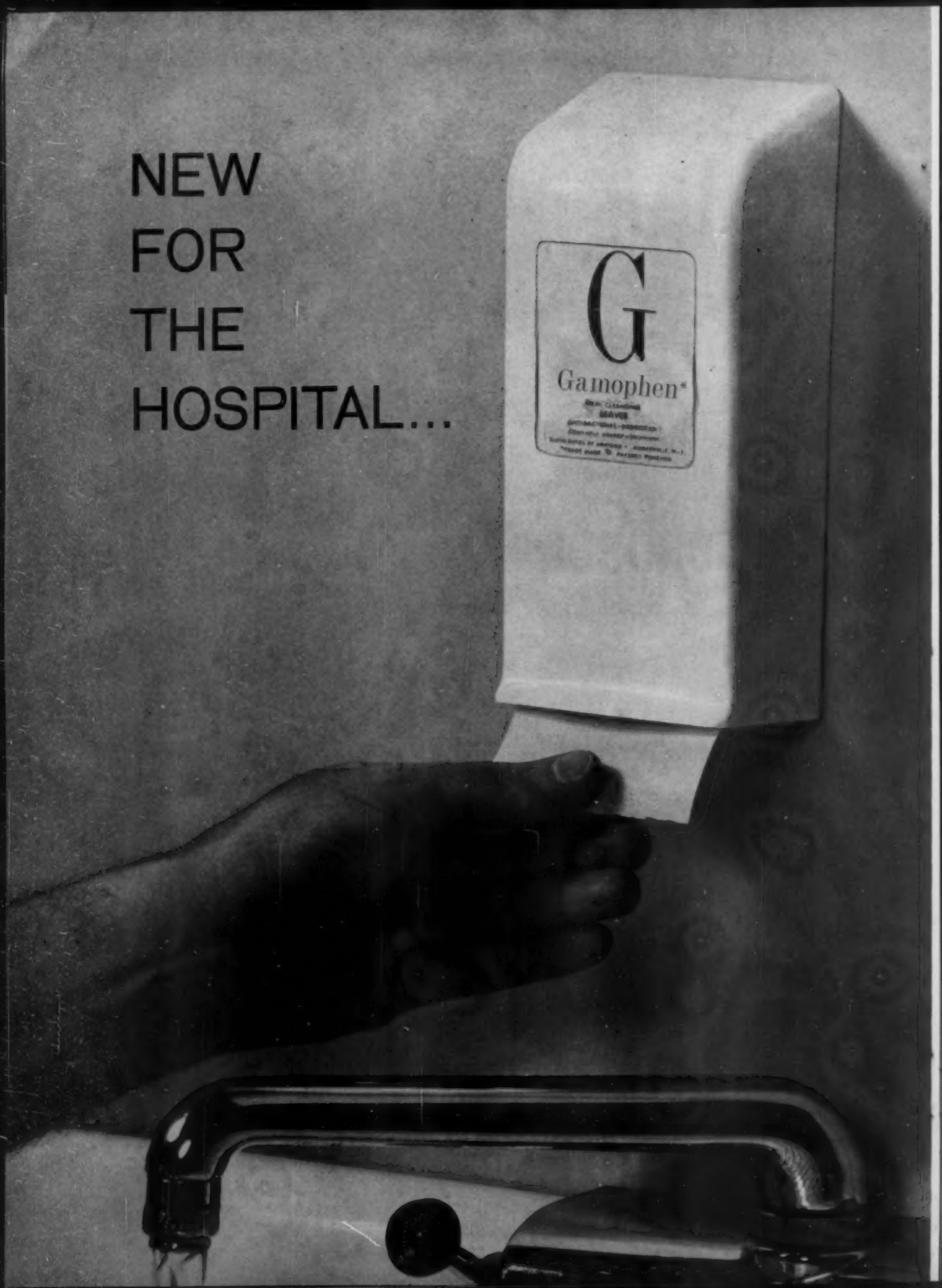
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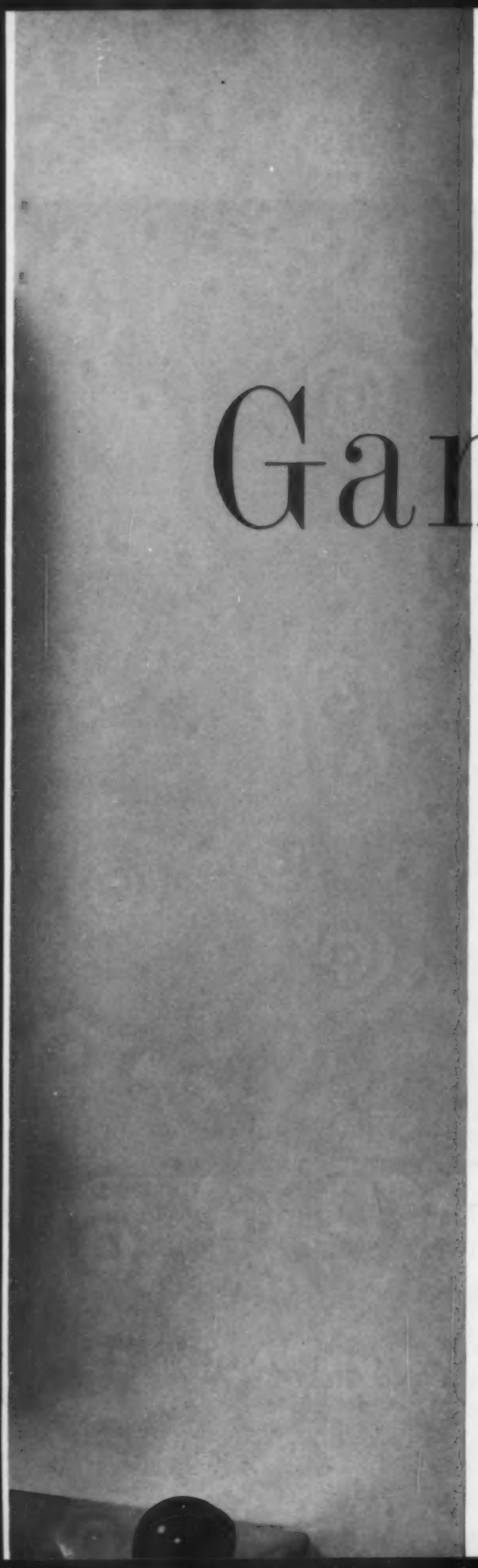

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HELP PREVENT CROSS-CONTAMINATION

You touch nothing but the soap you use ...and only **you** use the soap you touch. Attractive wall unit dispenses individual leaf of surgical cleanser that dissolves completely...lathers richly...cleans hands without detergent irritation...assures prolonged antibacterial protection. Ideal for nursery, examining rooms, washrooms, nursing stations. For free sample, write to:

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OUR LADY OF

THE 'HEALTH' OF OUR HOSPITAL ELEVATORS has always been maintained by specialists—OTIS maintenance men. Since 1950, we've found that these men have a wide variety of skills and an unmatched knowledge of parts, assemblies, functions, replacement procedures, testing and adjusting. How dependable has OTIS Maintenance been? First of all, it has always been available in a matter of minutes from the local OTIS office. For routine or emergency service. And it has kept our Passenger and Service Elevators operating like new for eleven years—to our complete satisfaction!

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Conducted by the Sisters of the Third Order Regular of St. Francis, Allegany, N.Y., the hospital of Our Lady of Lourdes was opened in 1950. It is a general medical and surgical hospital of 362 beds and ranks with nation's newest and finest. In 1960, it handled 10,252 admissions, 3,027 newborn, 4,154 operations, 178,400 laboratory procedures, 24,128 X-Ray examinations, and 40,184 out-patient visits.

The School of Nursing Building, part of a planned development program, was opened in 1960.

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STERILE BLADES

NOW you can take your choice between traditional B-P RIB-BACK carbon steel or *new* B-P stainless steel blades. Both are available in a puncture-resistant, *easily* opened package... both assure you of maximum cutting efficiency *every* time.

Whichever you choose

It's Sharp

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DANBURY, CONNECTICUT
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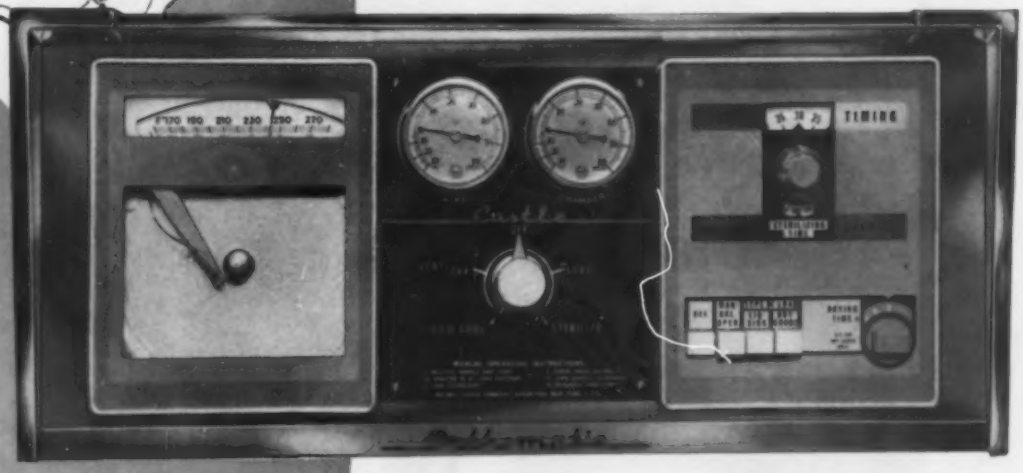
NEW SPEED and SAFETY in Sterilization



WITH Castle ORTHOMATIC

...the modern pushbutton sterilizer control system

New unprecedented speed with new sterilizing safety—all at the touch of a button—that's Orthomatic, Castle's revolutionary new sterilizer control system Central Supply, Surgery, Laboratory, Milk Formula Room—wherever you sterilize—the pushbutton Orthomatic System will out perform any sterilizer you are now using.

Find out how Castle Orthomatic can bring your hospital safer, more efficient sterilization, at less cost. Also available: Thermatic "60" and Manual Control systems.

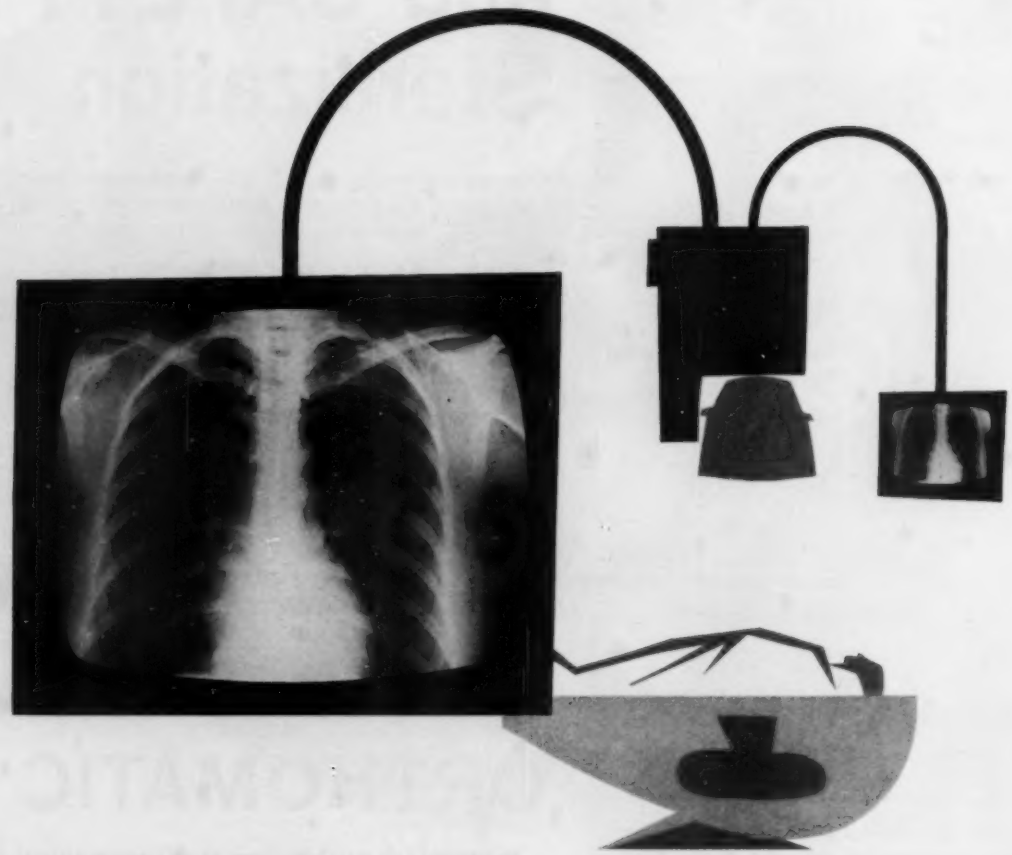
Look at these EXCLUSIVE features:

1. **DYNAMIC AIR ELIMINATION**—Automatic pulse system purges air, assures rapid, complete stream penetration.
2. **HIGH-SPEED JET HEATING**—Raises loads to sterilizing temperature 50-100% faster than conventional sterilizers
3. **DIFFERENTIAL LIQUID COOLING**—Cools three times faster than conventional sterilizers. It's automatic with the touch of a button!
4. **QUICK-SET TEMPERATURE CONTROL**—A finger's touch sets temperature anywhere from 212°F to 270°F.
5. **PUSH-BUTTON CONTROL**—No involved settings! A touch of a button and sterilization is programmed from start to finish.

Castle **LIGHTS AND STERILIZERS**

WILMOT CASTLE CO., 2007 E. HENRIETTA RD.,
Subsidiary of Ritter Company Inc.
ROCHESTER 18, N. Y.

For additional information, use postcard facing back cover.



This is Televex—the modern way in fluoroscopic diagnosis. With Westinghouse Televex, the radiologist enjoys such advantages as amplification up to 50,000 times for daylight fluoroscopy at the lowest radiation possible and remote diagnosis. Electronic magnification of image gives finest detail. The doctor and patient become a team.

For more information: Westinghouse Electric Corporation, X-Ray Department, 2519 Wilkens Avenue, Baltimore 3, Md. You can be sure... If it's

Westinghouse

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institutional control of bacterial enteritis and diarrhea

FUROXONE®

brand of furazolidone

Tablets / Liquid

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1. Mintz, A.A.: Antibiot. Med. 7:481, 1960.

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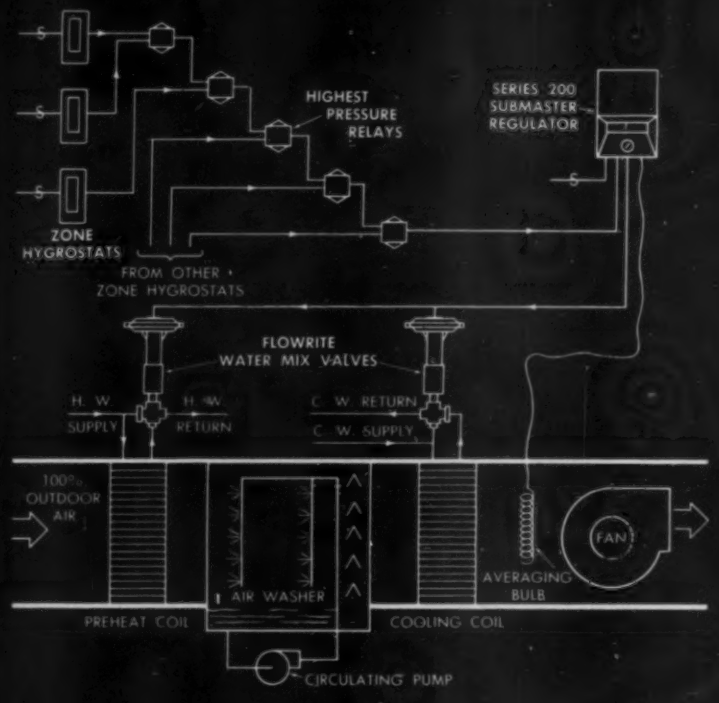
HOW TO GET OUT OF A SPACE SQUEEZE



At Holy Cross — where they automated "just about everything but patient care" — space was even more of a factor than with most hospitals. Money is always a factor.

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Consulting Engineer: J. F. Reardon & Associates, Van Nuys, California

Hospital Consultant: Gordon Friesen, Washington, D. C.

Award-winning Holy Cross Hospital is located in picturesque San Fernando Valley, California

a Series 200 Submaster which in turn operates the valves on either the pre-heat or cooling coil as required. The air washer, located between these coils, operates continuously without addition of heating or cooling to the spray water.

Another important innovation at Holy Cross is private facilities for individual rooms. The shower in each is protected by a Powers Hydroguard Thermostatic Control which prevents accidental scalding and fluctuations in water temperature.

For detailed information on the temperature control system and/or shower control system at Holy Cross request layout drawings and full description. Also ask for reprints describing Powers Control Systems in other institutions.

Heading up the planning staff were (left to right): Consultant, Gordon A. Friesen; Consulting Engineer, John F. Reardon; Architect, Gene Verge; and Administrator For Holy Cross Sisters, Sister Olivia Marie.

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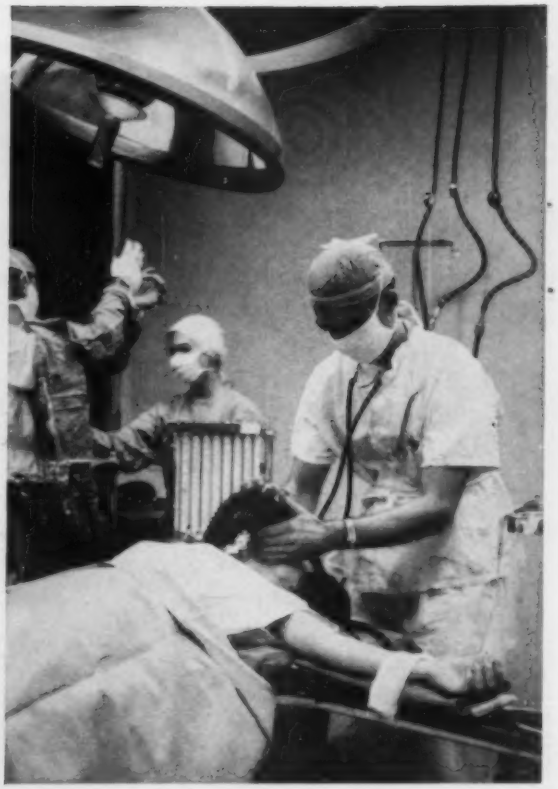

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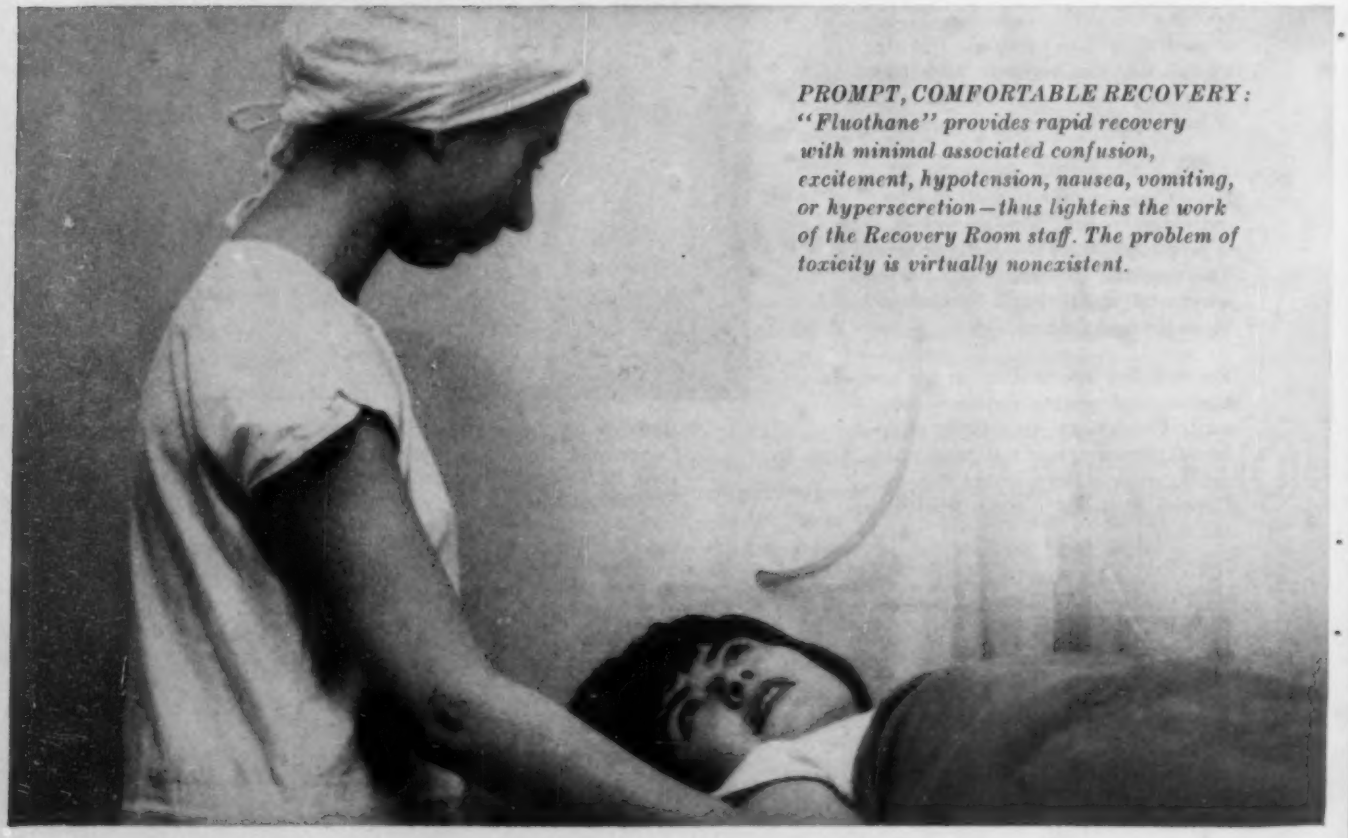

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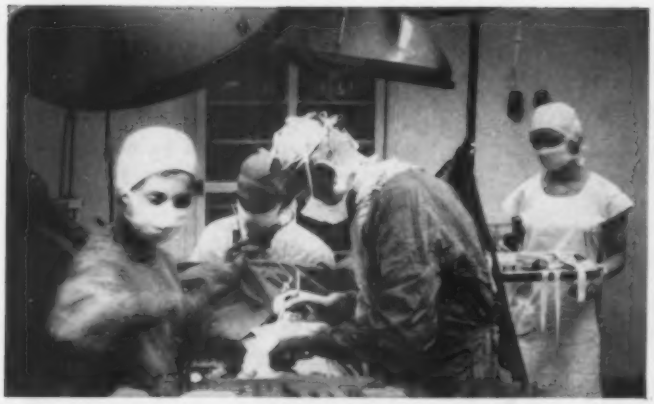

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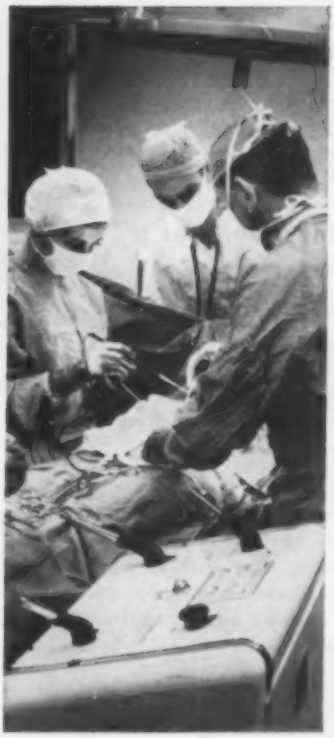
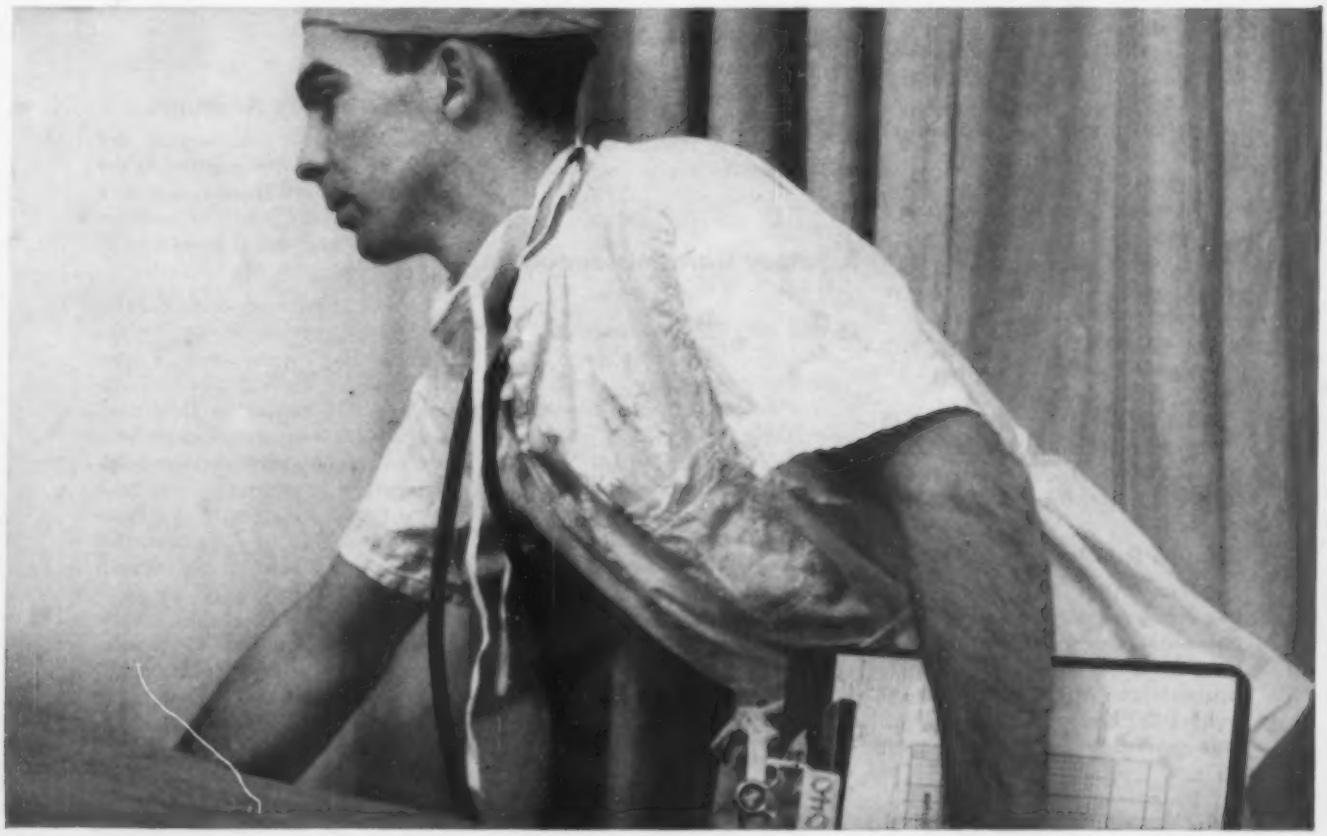
Supplied: No. 3125—Unit package of 125 cc. of Halothane stabilized with 0.01% Thymol (w/w).



NONFLAMMABLE, NONEXPLOSIVE: "Fluothane" can neither ignite nor explode. Where inhalation anesthesia is indicated, the surgeon is unrestricted in the employment of cautery or X-ray equipment.

6119



SMALL HOSPITAL QUESTIONS

Disinfecting Injection Sites

Question: Is there any standard approved method of skin disinfection for injection sites? We are attempting to standardize our procedure and have difficulty doing so because of the diversity of opinion. Any information you can give us regarding this will be greatly appreciated. — S.M.J., Minn.

ANSWER: I have found that there are almost as many methods of skin disinfection of injection sites as there are people doing it. I have also found that my views seem to be somewhat different from those of others — but, in any case, here they are:

1. Having on many occasions observed the poor condition of the transfer-forceps, the container, and the solution in which they are stored, I urge that technics be developed so that forceps will not be needed. Hands should be washed carefully using a good hexachlorophene soap before and after each patient contact. If hands are washed in this manner, I believe they can be used in place of forceps.

2. Central service should supply to each nursing unit a sterile container with 2 by 2 inch sponges every 24 hours. Cotton balls are too soft to provide the friction necessary for effective cleansing of the skin. Therefore, I suggest the use of a 2 by 2 inch sponge.

3. Hospitals can purchase for each nursing unit a plunger-type alcohol dispenser, which can be used as needed to moisten each sponge with a fresh solution of 70 per cent alcohol.

Although there are those who will challenge this technic, I believe it is an acceptable and effective procedure. — FRANCES GINSBERG, R.N.

Should R.N.'s Do I.V.'s?

Question: We have been permitting registered nurses to perform intravenous procedures. Recently the question of the legality of this practice was brought to our attention. I wonder if there are any specific rulings governing this practice, or if there is any reason why nurses should not take charge of intravenous administration. — M.E.K., Colo.

ANSWER: In answer to this question, one of our legal consultants replied:

"In most states the nursing practice and medical practice acts are not clear on the question of where the line is drawn between a nursing act and a medical act. In earlier times, puncturing of the skin was considered to be a medical act. Today, however, the medical and nursing acts have advanced tremendously and are continuing to advance; the law has not kept pace with these advances.

"In lieu of a strict legal pronouncement, certain procedures should be set up to protect the patient, the nurse, the hospital, and the physician. These might include: (1) permitting only R.N.'s to start and administer the fluids intravenously; (2) providing that the therapy be performed only upon the order and under the general supervision of a medical practitioner, and that the order refer to a specific patient; (3) providing the specific types of fluids and medications that may be administered, and (4) providing that the order be written and made a part of the patient's medical record.

"In this way standards will be set and known by all."

Salary Data Misleading

Sirs:

Your data on plant engineers' salaries in this department (page 54) of your June issue is very misleading.

One would judge from the heading over Table 1 that it is comparable with Table 2.

This is most emphatically not the case. As we pointed out to you, our answers pertained to stationary or boiler engineers, *and not to supervisory personnel.*

Jacques Cousin
Executive Director
Greater Detroit Area
Hospital Council, Inc.
Detroit

How To Discharge Patients

Question: I would be most grateful for what information you might be able to pass along on the following subject. What in general is considered good practice in discharging patients? — J.A., Vt.

ANSWER: All hospital personnel should exercise the same degree of care in relation to the circumstances in discharging patients as they would exercise in the care and treatment of such patients.

No patient should be discharged until the hospital has received the written approval of the physician charged with responsibility for the patient's physical condition. After a discharge order has been given, the hospital should see that the necessary assistance commensurate with the patient's condition is given to enable the patient to leave the hospital safely. If a patient is able to walk without any assistance, he may be permitted to do so, but patients in need of assistance should receive all that is necessary.

Patients unable to care for themselves, such as infants, aged or disabled persons, should be discharged only in the custody of relatives, friends or the representatives of a governmental or private social welfare agency.

How To Set Up Accounts

Question: Can you suggest any source of information relative to the division of hospital income; that is, a basic division that could be used for comparison with actual operation? — S.J.L., Ohio.

ANSWER: Your best source for this kind of information would be the American Hospital Association's manual entitled, "Uniform Chart of Accounts and Definitions for Hospitals." Chapter 4 of this manual deals with revenue accounts and describes a flexible chart of accounts. Account titles should be set up primarily on a functional basis; that is, an account for each separately functioning department of a hospital should be maintained. Expense accounts, of course, should be directly related to the revenue accounts. — ROBERT M. SHELTON, *executive director, American Association of Hospital Accountants, Chicago.*

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Two breaks with tradition

A.M.A. Gets Tougher With Unethical Doctors And More Lenient With Scientific Osteopaths

NEW YORK. — The American Medical Association has turned the heat on unethical physicians. For the first time, A.M.A. will be able to discipline such physicians without waiting for local medical societies to initiate action.

Meeting here late last month, the A.M.A. House of Delegates gave the association the right to suspend or expel an unethical physician "regardless of whether action has been taken against him at local level. . ."

Up to now, the A.M.A. lacked original jurisdiction in such cases. The new position was described by one delegate as a "complete reversal of character of the A.M.A." It followed a plea by Dr. Leonard W. Larson, incoming president, who asked the delegates to excise the "tiny fraction" of undisciplined doctors, "lest it grow like a cancer and thus pollute and corrupt the entire profession."

In another departure from tradition, the delegates decided that voluntary professional relationships with osteopaths who practice scientific medicine "should not be deemed unethical."

The approved policy suggests several ways to distinguish between "cultists" and scientific osteopaths and leaves this decision to state medical societies. Previously, professional relationships with all osteopaths had been considered unethical, although in some states, such as California, Kansas and Pennsylvania, practice did not follow policy.

According to the new approach, "the test now should be: Does the individual doctor of osteopathy practice osteopathy, or does he in fact practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the A.M.A., voluntary professional relationships with him should not be deemed unethical."

Taking up the touchy issue of medical care for the aged, the delegates approved a haymaker brought up from the floor in the form of a bristling amendment that attacked all legislation designed to finance this care under the social security system.

After the amendment passed, it was pointed out the wording suggested that the A.M.A. might strike if such legislation was enacted by Congress. Moving quickly, the house softened the language of the amendment, which originally asserted that the profession "will not be a party to implementing any system which is un-American and detrimental to the public welfare."

As finally approved, this sentence was changed to read "will not be a willing party to implementing any system which we believe to be detrimental to the public welfare."

In another controversial area, the house approved a report that recommended a mass vaccination campaign utilizing oral vaccine instead of Salk vaccine — a decision that produced a stormy series of telegrams from Dr. Jonas Salk, who warned that it placed the house "on embarrassingly uncertain scientific grounds."

The report predicted that mass vaccinations with an oral vaccine made of live, weakened viruses could "eliminate poliomyelitis as a significant public health problem."

In other official actions of especial concern to hospitals, the A.M.A.'s House of Delegates:

— Established a seven man commission to work with paramedical groups, such as optometrists, podiatrists and chiropractors. The commission gives a measure of control to the medical specialty groups involved, who argued that they were in the best position to work out relationships with these groups.

— Pruned the barbs from two resolutions critical of the Joint Commission on Accreditation of Hospitals and voted instead to ask the Commission "to modify existing policies so that the field representatives regularly review their observations in each hospital with responsible members of the medical and administrative staffs of the hospital."

— Rejected a third resolution attacking the Joint Commission's laboratory requirements and went on record as believing that "the overall policies of the Joint Commission in regard to hospital laboratory work are satisfactory."

— Applauded the progressive patient care programs now being

developed as providing "efficient utilization of facilities for intensive, intermediary and ambulant care."

— Plumped for higher pay for interns and residents by approving a special study committee report that urged this without going into dollar and cent details.

— Agreed that experience in obstetrics and surgery should be included in some additional two-year residency programs in general practice, and heard Dr. John W. Cline rap the "highly improper methods" used by a "totally separate organization to bring pressure on this house," a charge that seemed to be aimed at the American Academy of General Practice, which had sponsored the introduction of virtually identical resolutions from a half-dozen states.

— Asked the American College of Surgeons to modify its policies regarding surgical assistants so that, in effect, more G.P.'s can be used in this capacity.

— Refused to pass a statement asserting that doctors employed by medical care plans should *not* be denied professional rights and privileges.

— Opposed compulsory use of generic names while accepting the reference committee's explanation that this "does not mean that physicians should not use generic names, but they oppose the compulsion inherent in this kind of proposal."

— Stumbled over a good definition of free choice of physician, then threw up its hands and agreed with the reference committee on insurance and medicine "that it would be an impossible task to arrive at a definition which would be acceptable to everyone, on a nationwide basis."

— Acknowledged, with some regret, that it was "imprudent" to hold its 1963 clinical session in Las Vegas, and selected instead Portland, Ore.

— Named Dr. George M. Fister of Ogden, Utah, president-elect. ■

Bacteriological Investigation Required To Solve Infection Problem, Says Dr. Walter

NEW YORK. — The confined, crowded, intensely used hospital environment is itself the source of many kinds of cross-infection, Dr. Carl W. Walter, associate professor of surgery, Harvard medical school, said here last month.

Speaking at a symposium on the Hazards of Surgical Infection conducted by the American College of Angiology during the annual meeting of the American Medical Association, Dr. Walter said that emphasis on staphylococcal infection in recent years had resulted in failure to recognize the hazard of infection with other organisms.

"Gram-negative enteric bacteria, for example, have been comparatively unrecognized in hospitals," Dr. Walter said. Each hospital is epidemiologically unique, he added, and can solve the infection problem only by making its own careful bacteriological investigation.

"Most hospital administrators throw up their hands at the expense and organizational detail involved in maintaining a hygienic environment," he said.

Even in a comparatively "clean" hospital, Dr. Walter said, as many as 40 per cent of hospital personnel may be persistent carriers of infectious organisms, and 2 per cent or more may become "active disseminators" of infection.

Asked how disseminators could be identified, Dr. Walter described a program in which all personnel having close contact with patients was required to wear masks; after removal, the bacterial deposits in the masks were analyzed, and, in each case, the masks worn by disseminators were found to be heavily contaminated.

"Hospital employes who are active disseminators of infection must be removed at once from any contact with patients," Dr. Walter said, "and they may have to be shunted out of the health industry."

It is comparatively easy to keep a nurse or resident out of the operating room while he is actively infected, Dr. Walter added. "But it's hard to know what to do when it is the chief surgeon who is found to be spreading infection," he said.

Another member of the panel, Dr. H. Taylor Caswell, professor of surgery at Temple University School of Medicine, Philadelphia, criticized hospital apologists who have sought to minimize the infection problem by pointing out that the rate of cross-infection is no worse today than it was 20 years ago.

"It doesn't matter whether or not the rate is better than it was 20 years ago," Dr. Caswell said. "The important thing is that we have infection now, and we have to deal with it."

The rate of infection of clean surgical wounds varies by procedure, Dr. Caswell said. He reported an analysis of infected surgical cases at Temple University Hospital which showed a comparatively low infection rate for appendectomies, thyroidectomies and hysterectomies, and comparatively high rates for radical mastectomy and pneumonectomy.

The duration of the operation is still an important factor in the infection hazard, Dr. Caswell said. "A deft, rapid technic is important," he explained. "The surgeon who 'takes all day' has a higher rate of infection."

Dr. John A. Schilling, professor of surgery at the University of Oklahoma School of Medicine, described results achieved at the University Hospital in controlling surgical infection by the use of a sprayed-on plastic drape. Infection rates for comparable procedures were significantly lower among patients on whom the plastic drape was used than in a control group, he reported.

Dr. Schilling also described the plastic "isolette" or separated sterile environment for surgical patients that has been developed at the Walter Reed Hospital in Washington, D.C. The isolette is practical for any procedure involving the body cavity or soft tissue of an extremity, he said.

Dr. Caswell and Dr. Walter objected that the isolette is cumbersome and inconvenient for the surgeon.

"There are limits to these exotic efforts to stop infection," Dr. Caswell said, adding, however, that this did not apply to the sprayed-on plastic drape, which he felt was useful.

Dr. Robert F. Hagerty, associate professor of surgery, Medical College of South Carolina, reported infection rates resulting from several different technics for dressing burns, and Dr. William T. Foley, Cornell University Medical College, New York, discussed infections in peripheral vascular disease. ■

wire from Washington

AGED, DRUG ISSUES GET LITTLE ACTION

The two issues that have aroused the greatest public interest this year — medical care of the aged and new drug controls — are getting nowhere fast. Hearings are assured on both, but that's all.

It took Chairman Estes Kefauver of the Senate anti-trust and monopoly subcommittee more than six months to pin the American Medical Association down to testifying (on his terms) on proposed new drug legislation.

Starting last fall, Senator Kefauver publicly invited the A.M.A. to appear before his subcommittee, which was then holding "investigative hearings" on drugs. He particularly wanted to get the doctors' views on generic name prescribing and the advantages and disadvantages of hospital formularies.

In March, Senator Kefauver took another tack. Legislative hearings were planned on his drug bill, and he wanted to open them up with testimony from A.M.A. witnesses. In blunt terms he called on the association to turn over to the subcommittee detailed information on:

1. Advertising contracts for the *Journal of the American Medical Association*, financial records of the journal, data on the use made of journal profits.

2. A history of the A.M.A. Council on Drugs, with particular reference to the reason the council stopped evaluating drugs.

3. An explanation of the methods used to screen claims for drugs advertised in the journal.

4. Results of any drug sales survey that the A.M.A. might have conducted.

Subsequently, Senator Kefauver subpoenaed records of a number of public relations firms in the pharmaceutical field.

When he thought A.M.A. was taking too much time in assembling this information for his subcommittee, Senator Kefauver sent the association another letter, asking that the data be sent along piecemeal. Eventually, A.M.A. started the material moving and informed the Senator that it would be prepared to testify on July 5 and 6. Senator Kefauver then rescheduled his hearings to start at that time.

At the hearings A.M.A. will be represented by Dr. Hugh Hussey, dean of Georgetown Medical School, and Dr. Ernest B. Howard, the association's assistant executive vice president. Preparations were immediately started to develop exhaustive testimony that probably will take more than the scheduled two days.

A.H.A. TO DEFEND FORMULARIES

American Hospital Association also probably will testify at the hearings, concentrating on a defense of generic-name prescribing and formularies. At this writing it is not known whether A.H.A. will offer its views through witnesses or merely send a statement to the subcommittee.

One rumor, with some verification, is that Senator Kefauver is cooperating with the Kennedy Administration in an over-all campaign to discredit the A.M.A. at his hearings so its lobbying efforts will be less effective when a showdown comes on medical care for the aged under social security.

When that bill comes up for its brief hearings, probably in late July, H.E.W. Secretary Ribicoff will be prepared to turn on all possible public relations pressure. His objective is not to bring about passage this year — that already is regarded as impossible — but to revive public interest in the proposal, which A.M.A. has been fighting for more than 10 years. A.H.A.'s position remains the same — opposition to this particular bill at this time, but an admission that the social security approach may have to be the ultimate choice.

Meanwhile, House-passed appropriations bills for health and medical programs are moving steadily ahead in the Senate, with Hill-Burton officials expecting a substantial increase.

Only a few administrative problems are arising, such as the question of whether the Cancer Institute should be permitted to continue paying 100 per cent of the cost of constructing cancer research facilities while U.S. puts up only 50 per cent of the cost of other research plants.

HEALTH BILLS HAVE THEIR HEARINGS

At least 10 more bills involving health and welfare are actively under consideration by congressional committees.

To someone dropping in on Capitol Hill for his first visit, it would appear that a vast reorganization of the federal statutes is about to take place. Actually, it is merely the time of the year when committees and subcommittees and their chairmen have the center of the stage. Action will come on a few of the bills, but on very few. Most hearings are being conducted to satisfy the White House, which has a record-breaking peacetime legislative program, and individual senators and representatives who want to make a showing for their particular bills, even if they know passage is out of the question.

A good example of what is not happening — but appears to be happening — is President Kennedy's program for aid to medical schools and medical students.

For construction, scholarships and faculty pay, it calls for $750 million spread over 10 years. There is no argument whatever about the need for some federal assistance

in this area. Even the American Medical Association, which is eternally cautious about federal intrusion into medicine, is not opposing this bill, although it is supporting only part of it.

Senate hearings on this legislation have been concluded, but with adjournment not more than two months away, no hearings have been held on the House side and none is scheduled. Furthermore, the House interstate and foreign commerce committee is becoming bogged deeper and deeper in high priority work. Present prospects are that it will not even hold hearings on this program.

Another part of the Kennedy plan to educate more physicians calls for loans to medical and dental students through amendment of the National Defense Education Act. Appropriations would start at $5 million and increase by $5 million a year for six years. After that there is no price tag on the legislation. Although this has strong White House backing, its progress in Congress is slow: a one-day hearing by a House subcommittee, no hearings in the Senate — and at this stage none planned. American Hospital Association is supporting this bill, as it is the other aid to medical education measures, but A.H.A. wants an amendment that would make residents, interns and professional nurses eligible for the assistance.

Also, the one-day-hearing curse probably has doomed the bill for federal support of community facilities. This calls for $10 million a year, but there are a number of "open-end" provisions that make it impossible to calculate the real cost. This legislation is stirring up some opposition because it circumvents the Hill-Burton program's built-in controls. Even before arrival of the bill in the Senate, it is understood that Chairman Lister Hill of the labor and public welfare committee was disturbed at the threat to the hospital construction program that he co-sponsored.

SURVEY CHECKS UP ON ITSELF

The U.S. National Health Survey uses a complex, tightly controlled system for determining how many people are ill, for how long, and for what reasons. It makes use of door-to-door interviews, based on standardized questionnaires.

But, careful as this operation is, it is not entirely foolproof. To check up on itself, the survey hired the University of Michigan's Survey Research Center. Where survey interviewers asked information from persons in their homes, the second team checked hospital records to determine just how accurate were the original data.

Here are some of the findings:

When deliveries are excluded, people up to age 65 follow a uniform pattern of error (or "underreporting") when asked about their hospital stays; over 65, there is a tendency to forget more of the hospital trips.

There is a relationship between education and accurate reporting or recall of hospital experience; the percentages of error are noticeably greater for persons who have not completed high school. One explanation is that the better educated people have a higher degree of "motivation" in everything — including answering questions about their own health. For some unexplained reason, family income appears to have more influence on correct answers than does education; the greater the income, the more accurate the information furnished about medical problems.

Persons with chronic illnesses and those whose stays in the hospital are unusually long are relatively accurate in what they tell the interviewer, in contrast to acute illness and short-stay cases. Reports are more accurate for deliveries, gall bladder operations, appendectomies and hernia repair than for any other conditions for which people are hospitalized.

The statisticians come around to this observation about human nature:

"Those who did not enjoy the interview were less consistent in reporting their hospitalizations."

NOTES:

Through June, the country was experiencing a remarkably low incidence of poliomyelitis; latest P.H.S. count shows just under 200 cases, or only half the total at the same period last year.

Direction of the government's cancer research programs came under criticism at a Senate appropriations hearing. Dr. Freddy Homburger, Cambridge researcher, said too much emphasis is placed on finding a cure for cancer and not enough on learning how to prevent it.

New legislation in House and Senate would set up a permanent federal unemployment compensation program — with hospitals mandatorily covered. It has the support of the Kennedy Administration.

American Hospital Association and the surgeon general's advisory committee on graduate nurse training are cooperating in a study of the whole problem of nurse education. They plan to publish a joint report no later than next January 1.

Trouble is brewing over N.I.H. policy of allowing part of grant money to be used for modernization and renovation of facilities; the H.E.W. general counsel cites the fact that this runs counter to the $30 million a year research construction program, under which the institution must put up half the money.

Multidisciplinary clinical research centers at 13 more schools have received federal grants ranging from $100,000 to $452,000. They are: Arkansas, Colorado, Georgetown, Georgia, Northwestern, Chicago, Iowa, Johns Hopkins, Yeshiva, Pittsburgh and Marquette universities and Montefiore Hospital (N.Y.) and Tufts-New England Medical Center.

"Citizen witnesses" who annually appear before the Senate appropriations subcommittee to urge more money for research in the past often have enlivened their testimony with color films; this year these research experts produced patients who were living testimony to the value of research.

Using federal funds, University of Wisconsin will construct a primate colony to emphasize functions of the brain and psychological disorders; a similar colony at University of Washington will concentrate on neurophysiological and cardiovascular research.

Federal Trade Commission has devised a new weapon for use against deceitful advertising practices in foods, drugs and cosmetics; it has armed its staff with power to demand that suspect companies produce specific records under threat of fines.

The Modern Hospital
JULY 1961

LOOKING AROUND

Computer Medicine

FOR many years, a few physicians have been dreaming about the day when they could use computers to take the drudgery out of diagnosis by feeding symptoms and findings into the machine and getting the answers instantaneously, without having to spend hours poring over medical encyclopedias, textbooks and journals trying to make sure no possibility has been overlooked in the difficult brainwork of differential diagnosis.

Well, the day when this can be done by machine is here — in fact, it's been here for some time now. Computer engineers insist that the machine is equal to any diagnostic task that can be solved by information and logic, as most can be, but the machines still aren't being used — for the same reason you wouldn't use a crowbar to open a package of cigarets: In most cases, it isn't needed. "If all that came out of a monumental paper shuffling and magnetic tape twirling were a printed list of diagnostic possibilities in the not especially puzzling case of the not especially ill John Doe, this would be a poor product for a massive scientific effort," said a recent paper by Dr. George R. Meneely of Nashville, Tenn., a physician who is as familiar with Boolian algebra as he is with Buerger's disease. "There are not enough 'problem cases' at any one moment in the average busy hospital to return the investment on a desk calculator, let alone a giant electronic computer."

As a matter of fact, the desk calculator, or slide-rule, method of establishing the diagnosis in difficult cases has been tried out. Several years ago, Dr. F. A. Nash of London introduced the Grouped Symbol Associator, a logoscopic rule which operates by matching strips of signs and symptoms against a rule listing several hundred diseases, grouped according to bodily systems. "A book will give the causes of a single symptom or sign, but, unlike the logoscopic rule, it cannot deal with combinations," said Dr. Nash. "Yet it is just by considering the causes of combinations of symptoms that the most rapid narrowing down of range of possibilities is secured."

With Dr. Nash's slide rule as with the computer, however, the physician still has to run the last mile by himself. "You have to use the Grouped Symbol Associator realizing that it will take you somewhere near your diagnostic destination and so save you a lot of effort," Dr. Nash explained, "but you will by no means usually be taken from door to door, and if you do not know your way around, you could get off at the wrong place."

Many doctors, perhaps recalling the *tour de force* performances of their old professors who made diagnoses by odor on ward rounds, recoil in horror from any suggestion that diagnostic judgment should be aided by mechanically or electronically assisted thought. Laboratory tests and electronic measurement of vital signs are acceptable, in this view, but electronic logic is unthinkable and would threaten the doctor-patient relationship.

Computer-minded physicians like Dr. Nash have assailed this position. "Diagnostic data processing and mechanically assisted thought may not only make the doctor more efficient, while relieving him of some part of the great load he carries," one of them said not long ago at a meeting of an esoteric group that is concerned about these things, "but will also give the time and opportunity for doctor and patient to have a more human relationship, and for the patient to receive more individualized attention."

The most enthusiastic explorers in the field, moreover, acknowledge that the machine is unlikely to replace the brain. "I don't believe anyone is proposing a method by which a computer will take a poor diagnostician and make him into a good one," Dr. Jordan Baruch of Cambridge, Mass., said recently. "I think we are proposing to use a computer in order to make an excellent diagnostician out of a good one. If the medical practitioner were fool enough to feed the symptoms into the computer without a preliminary evaluation of his own, such a physician deserves what he gets. He should probably not be allowed either to practice medicine or to get near a computer."

Good or bad, computer medicine seems certain to be included in the shape of things to come, but the day is not yet near when the busy practitioner can excuse himself from the patient with baffling symptoms in his consulting room to go into his study and call a machine instead of a friend. The machines are ready for this, but doctors and hospitals are not. Before the computer diagnostic center becomes a reality, standard technics for recording histories, physical examinations, and laboratory findings will have to be developed; the machine can answer only when the right questions are asked. Some indication of how far we have to go was given the other day by one of the men who is doing research in computer diagnosis: He called nine doctors, and got nine widely divergent history and physical examination forms.

Whatever happens, plainly, the computers are going to have a lot of time to keep on playing chess.

No Hands

ALONG with some 50 other reporters representing interests that ranged from the *New York Times* to *Factory* magazine, we attended a press conference the other day staged by The Brass Rail, a New York restaurant chain that has gone into the contract food service business. According to a release handed out at the conference, Brass Rail is prepared to deliver as many as 30 million precooked, frozen meals a year to be reconstituted and served from coin machines operated by franchised dealers who are now being signed up around the country — a maneuver that is calculated to bring Baked Haddock Creole to high school children and factory workers everywhere at the drop of 65 cents.

In a film shown at the press conference, we watched haddock and other dishes being prepared under the supervision of a chef who looked competent, if not intimidating, in his high white hat in the movie but just conspicuous when he showed up in the same outfit at the press conference. After the picture, and a few speeches, we were taken to a "kitchenless cafeteria" in the General Electric Building, where 1600 G. E. employes a day get their bills changed into coins and their coins into food, including Baked Haddock Creole if they choose, by automation. Answering a reporter's question, a man opened the machine and let us peer inside at a hundred or so packaged meals neatly stacked in the heating element. When the clerk or secretary or bookkeeper decides whether it shall be Haddock or Lasagne or Salisbury Steak or Sausage and Mashed Potatoes and pushes the appropriate button, a neatly wrapped plastic dish is ejected from its stack and slides down the chute into sight.

Another machine serves salads, sandwiches and snacks; still another — surprisingly, the most complicated of all mechanically — makes fresh drip coffee in 20 gallon batches and serves it a cup at a time in the fashion that has become familiar to subway riders and baseball fans. We didn't see the inside of the money machine but were fascinated to watch as the customers fed it $1 and $5 bills and got back their change — accompanied, in the latter case, by a roll of ones.

While we were watching, every person who used the machine stopped to count his change — possibly proving that man still mistrusts automation, even when it gives him Baked Haddock Creole for lunch.

Glass Arm

UNDER the doctrine of *Respondeat Superior,* hospitals are generally held responsible for the acts of interns, the law has ruled, exceptions having been noted on occasions when the intern was performing a purely medical act under the direct supervision of a staff physician, and not acting as a hospital employe. In a recent decision, an appellate court in Ohio added an interesting, if not aberrant, footnote to the body of law on intern responsibility.*

An intern on emergency room duty had treated a patient for lacerations, it turned out, leaving two splinters of glass inside the wound "which caused great pain and discomfort until removed as the result of a second operation." In the court of first jurisdiction, a jury found the intern negligent because he had failed to call the senior doctor in charge, but the court reversed this ruling because the matter of calling a senior doctor was not included in the plaintiff's pleading.

Considering the basic question of whether glass in a closed wound constitutes negligence, the appellate court held that treatment did not deviate "from the standard of care, diligence or skill employed in the examination and treatment of such cases by competent physicians and surgeons practicing in the community" — a ruling that could be considered uncomplimentary to the doctors of Ohio.

"However, the standard of skill is not absolute in all cases," the court continued. "It would be unreasonable to exact from an intern doing emergency work in a hospital that high degree of skill which is impliedly possessed by a physician and surgeon in the general practice of his profession, with an extensive and constant practice in hospitals and the community.

"What is required in the case of an intern is that he shall possess such skill and use such care and diligence in the handling of emergency cases as capable medical college graduates serving hospitals as interns ordinarily possess under similar circumstances, having regard to the same or similar localities, and the opportunities they afford for keeping abreast with the advances in medical and surgical knowledge and science."

Going right down the line for the defendant hospital, the court then knocked out plaintiff's contention that the hospital should be held liable because it was engaging in the illegal practice of medicine. "Employment of interns and residents by hospitals has been an accepted feature of medical education for many years, not only in this state, but throughout the various states of the union," the decision said. "The fact that a modest compensation is sometimes given them by the hospital for their support while in training, and the further fact that the relationship of master and servant exists, do not create grounds for holding that the hospital is practicing medicine. The hospital, rather than practicing medicine, is in the business of rendering a service to the community and to the intern himself. The intern's chief and primary reward is the instruction which he receives in medical and surgical practice from the hospital staff physicians when assisting or watching them in the treatment of all types of cases, and in the temporary care of emergency cases. Interns do not hold themselves out to practice medicine, nor do they have patients of their own."

The fact that the intern was unlicensed in Ohio was also dismissed: "The great weight of authority supports the view that . . . failure to procure a license does not in itself give rise to any right of recovery by . . . plaintiff. . . . To maintain such an action, the plaintiff must show that the result complained of was due to negligence or unskillful treatment."

As it relates to the hospital practicing medicine the decision is sensible; any other ruling on this point would have the effect of eliminating house staffs altogether. In its other aspects the decision appears to leave the patient hung up with his grievance, as he was with glass in his arm.

*Rush v. Akron General Hospital, 171 N.E. (2d) 378 (Ohio).

How To Measure Hospital Effectiveness

Technics and criteria developed in Michigan provide do-it-yourself tools that can help hospitals and doctors find out how good a job they are doing

Aaron Cohodes

HOSPITALS that want to gauge their effectiveness now have new tools available to do the job themselves.

The tools were developed by investigators* at the University of Michigan after three years and $380,000 worth of research. Working with the researchers were panels of outstanding, board-certified physicians in seven specialties: general surgery, internal medicine, gynecology-obstetrics, orthopedics, otolaryngology, pediatrics and urology.

These physicians solved perhaps the biggest problem confronting the researchers: They established limits of normal hospital stay for 18 diagnoses. The limits were kept flexible and broad so that reasonable variations in medical practice could be accommodated. Provision was made for complications that affect length of patient stay.

Take, for example, a case of appendicitis.

The general surgery panel, with Dr. Frederick A. Coller, former professor and chairman of the department of surgery, University of Michigan, as chairman, set the usual length of postoperative stay for appendicitis at five days. A range of from three to seven days, however, was considered appropriate.

The reasoning of the panel went something like this: No one can say with confidence that every patient should be hospitalized for precisely five days after he undergoes an appendectomy without complications. The science of medicine is simply not that definite. It is definite enough, however, to permit a panel of experienced surgeons to say that, following an uncomplicated appendectomy, a patient should stay in the hospital no less than three days and no more than seven days. If he stays a longer time (overstay) or a shorter time (understay), there should be a justifiable medical reason.

In every such case, these reasons were painstakingly examined in personal interviews with the physicians involved. More than 1700 cases were reviewed in this fashion.

After the physician-to-physician interviews, each of the 5750 patients included in the study was classified as having had an appropriate hospital stay, an overstay, or an understay. With this information, it was possible to determine the number of appropriate patient days and the number of inappropriate or unnecessary patient days. It was also possible to obtain a new kind of measurement of hospital effectiveness: the number of patients who did not stay in the hospital as long as their diagnoses indicated they should.

These data were then easily translated into percentages and ratios. Key finding was that one out of every six patients discharged either stayed too long (9.6 per cent) or left too early (6.8 per cent).

This finding, of course, relates only to the 18 diagnoses for which criteria were established in the study. These are: fibromyomata of uterus, asthma, diabetes mellitus, acute myocardial infarction,

*A report of findings from this and other parts of the Michigan study appeared in the June issue of The Modern Hospital, p. 57.

HERE ARE THE MICHIGAN CRITERIA FOR THREE DIAGNOSES

Appendicitis

I. Indications for Admission

A. Presumptive diagnosis of acute appendicitis
B. For interval appendectomy (elective)

II. Hospital Services Required

A. CBC
B. Urinalysis
C. Operating room
D. Anesthesia

III. Hospital Services Consistent with Diagnosis

A. Various diagnostic studies to rule out other diagnoses (especially in interval appendectomy)
B. Pyelogram
C. Barium enema (in interval appendectomy)
D. Scout film of abdomen or KUB film
E. Chest x-ray (desirable)

IV. Expected Length of Hospital Stay

A. Sometimes, if attack subsides, patient may go home in one day (no surgery)
B. Usual stay five days postoperative (may be individualized, range three to seven days)
C. In acute attack suspicion should be confirmed within 24 hours, therefore one day preoperative length of stay at most
D. Greater length of stay between admission and operation may indicate:
1. Diagnostic difficulty (as evidenced by diagnostic procedures done on each day of delay)
2. Complications
3. Associated diagnoses. Therefore, this period should be examined for reasons of delay
E. Interval appendectomy (no acute symptoms present) usually shorter length of stay postoperative — four days

V. Complications Extending Stay

A. Peritonitis — localized or diffuse
B. Drainage tube
C. Infected wound
D. Pulmonary complications
E. Pyelophlebitis
F. Phlebitis
G. Small bowel obstruction
H. Single abscess or multiple abscesses (in various or multiple sites)
I. Urinary tract infection

VI. Indications for Discharge

A. Patient ambulatory
B. No complications
C. Normal eating, bowel movement, urination restored
D. Afebrile on day of discharge

Inguinal Hernia

I. Indications for Admission

A. Presence of an inguinal hernia

II. Hospital Services Required

A. CBC
B. Urinalysis
C. Chest x-ray
D. EKG (if 70 years of age or over)
E. Operating room
F. Anesthesia

III. Expected Length of Hospital Stay

A. Preoperative: one day maximum in elective procedures
B. Postoperative:
1. Infant — 24 to 48 hours
2. Children, 1-12 years — one to three days
3. Over 12 years — five to six days (primary hernia, uncomplicated)
4. Over 70 years — seven to nine days
5. Recurrent hernias — seven to nine days
6. Bilateral hernias
a. Done simultaneously — same length of stay
b. Done sequentially — 12 days (operations done one week apart, postoperative stay five days after second)

IV. Complications Lengthening Stay

A. Size of hernia, *i.e.* very large hernia — longer stay
B. Strangulation of bowel
C. Postoperative wound infection
D. When bowel resection is required
E. Prostatism
F. Trauma to testes blood supply or vas deferens
G. Cardiovascular pulmonary complications

V. Indications for Discharge

A. Wound apparently healthy
B. No complications
C. Normal eating, bowel movement, urination reestablished
D. Afebrile on day of discharge

Similar criteria were also established for fibromyomata of uterus, asthma, diabetes mellitus, acute myocardial infarction, bronchopneumonia, T and A, diarrhea (under 2 years), cholecystitis, urinary tract infection, urinary tract calculus, conditions of pregnancy, abortion, delivery, fracture of radius and ulna, and fracture of the neck and femur.

Prematurity

Definition: Newborn under 5 pounds, 8 ounces in weight

I. Indications for Admission

A. At birth — weight of less than 5½ pounds
B. From home —
1. Weight of less than 5½ pounds.
2. Infection
3. Respiratory difficulty
4. Feeding problem

II. Hospital Services

A. Required
1. Hemoglobin — none on 10 days of age or under; one from the 11th to 20th day inclusive; one additional within each 10 subsequent days of hospitalization
2. Premature nursery or other adequate incubator facilities if the length of stay is more than seven days.
3. Isolation technic (general failure to record use of isolation technic in medical records makes it impractical to use this criterion)
4. Special formulas
B. Consistent with diagnosis
1. Transfusions, when indicated
2. Oxygen therapy, when indicated
3. IV fluids, when indicated
4. IV cut-downs, when unavoidable
5. Bilirubin (about 50 per cent of prematures get this)

III. Probable Length of Hospital Stay

A. From birth to mother's expected date of confinement
B. One and one half week stabilization period plus one week for each one-half pound weight gain to discharge weight of 5 pounds.
C. No average predictable. Indication of appropriateness of length of stay is primarily the presence of the discharge criteria. Where the discharge criteria are met at birth, the mother's uncomplicated postpartum length of stay controls.

IV. Contingencies That May Prolong Hospital Stay

A. Feeding difficulties
B. Infection
C. Respiratory difficulties
D. Congenital anomaly

V. Indications for Discharge

A. Weight of 4½ to 5 pounds
B. Ability to bottle-feed and gain weight
C. Otherwise healthy

bronchopneumonia, T and A, appendicitis, inguinal hernia, diarrhea (under 2 years), cholecystitis and cholelithiasis, urinary tract infection, urinary tract calculus, conditions of pregnancy, abortion, delivery, fracture of radius and ulna, fracture of neck and femur, and prematurity.

In simple cholecystectomy, the panel indicated that a stay of from seven to 10 days is considered normal. If, however, exploration of the common duct is also required and a T-tube is left for drainage, from 15 to 20 days' postoperative stay is required.

In inguinal hernia, the panel indicated precisely the effect of age upon the length of postoperative stay. The length of stay ranges from 24 to 40 hours in infancy to from seven to nine days for patients over 70 years of age. The panel indicated that when bilateral herniorrhaphy is done simultaneously, there is no need for longer stay.

Myocardial infarction proved impossible to categorize as to length of stay. The panel agreed that a minimum of 21 days postinfarction is essential for good care. The panel also felt that, in the absence of complications and the presence of good outpatient laboratory facilities and convalescent care at home, the twenty-first day can also be the expected date of discharge. It was expected here that the range of hospital stay would be rather wide because of the unpredictable nature of this disease.

In establishing the criteria, the longest debate concerned the length of stay in uncomplicated vaginal delivery. The gynecology and obstetrics panel, with Dr. Tommy N. Evans, professor of obstetrics and gynecology, University of Michigan, as chairman, unanimously agreed that optimum effective hospital stay for primiparas was six to seven days and for multiparas, six days. The panel also agreed that "experience has shown the feasibility, although not the desirability, of a three-day postpartum discharge if an excellent visiting nurse facility existed to provide close supervision over the postpartum woman and infant." The panel defined three days' postpartum stay as the minimal effective stay for both primipara and multipara.

In their report, the researchers provided the following general observations about the criteria:

1. They are extremely detailed.
2. They are fairly rigid with regard to standards for admission to the hospital.
3. They are flexible otherwise.
4. Detailed provisions are made for variations in patients and contingencies of their illnesses.
5. The ranges of length of stay are in general large; estimates of the amount of overstay or understay made are therefore conservative.
6. Some standards are not actually medical (age, distance from the hospital, availability of care at home, number of children), but are considered medical in the criteria because of their intimate relationship with the decision that must be made for clinical reasons.

In addition to setting an appropriate span of hospital stay for each diagnosis, the panels also established the following points:

1. The criteria for admission.
2. The procedures both necessary and consistent with the diagnosis.
3. Complications affecting length of stay.
4. Indications for discharge.

The researchers also suggested ways in which physicians and administrators can use these criteria for studies of effectiveness in specific hospitals. Although their study was limited to 18 diagnoses, they are confident that similar criteria for other diagnoses could be developed along the same lines.

In most situations, the researchers believe, it will not be necessary to develop different criteria for the 18 diagnoses, but they admit that "there will probably be legitimate differences of opinion among physicians as to the correctness of some of the criteria." When this happens, they point out, "the physicians on a particular hospital staff can develop their own criteria for a review of the effectiveness of care in their own hospital. An area hospital council might develop such a study of a group of hospitals, using criteria set up by panels of physicians from that area."

Hospitals Can Establish Their Own Criteria Following the Michigan Pattern, Researchers Suggest

The tools to undertake such studies will soon be easily obtainable. A two-volume report of the Michigan study — including the 18 criteria and the details of their preparation — will be published this fall by the Hospital Research and Educational Trust of the American Hospital Association.

With this information, the appropriate medical staff committee of almost any hospital can (1) review a sample of medical records in the selected diagnoses, (2) isolate anomalous hospital stays, (3) check the reasons for these stays by interviewing the admitting physicians, and (4) obtain an indication of how effectively the medical staff and individual physicians are utilizing hospital facilities.

It is clear that the results of such studies can help hospitals and physicians improve their performance to the communities they serve. Perhaps best of all, this research can be done by the medical staff itself, according to criteria it has approved — and without recourse to outside agencies.

The important advantage to such investigations, emphasizes Walter McNerney, director of the study, "is that the data obtained can be used to give the public and other interested parties valid evidence that most hospitals and medical staffs are operating within reasonable grounds."

Up to now, this kind of evidence has been hard to come by. ■

Introducing Walter J. McNerney, new president of the Blue Cross Association

McNerney Likes To Get Things Moving

NEXT month, Walter J. McNerney, 36, will become president of the Blue Cross Association.

A university professor, he'll soon move from the campus into the most influential position in the prepayment field while many a veteran Blue Cross man scratches his head and wonders how in the world he got there.

There's an easy answer. Anyone who knows Walter McNerney can supply it. He got there mostly on intelligence.

"I've seen him in action on a council — in some pretty stiff company." said an American Hospital Association official not noted for dishing out high praise. "After a few meetings and a little verbal combat, anyone could tell he was the smartest man in the room."

Certainly the word intellectual explains much of McNerney's strength. It's inaccurate and misleading, however, to dismiss him as an inhabitant of an ivory tower.

He's no egghead. Nor is he a dreamer whose imagination, in Shakespeare's phrase, bodies forth the forms of things unknown. Rather, he is an unflinching, confident, go-it-alone realist with his own ideas on just about everything and a strong desire to make a lasting social contribution. Not only does he think problems through in terms of underlying issues, he likes to get out of the classroom and do something palpable about solving them.

For years he pleaded for new tools that could be used by physicians and hospitals to gauge their effectiveness and give evidence to the public that they are doing a good job. When such tools were slow in being developed, McNerney backed up his pleas with performance and helped fashion them himself.

A prospectus outlining his plans turned loose grants totaling $380,000 from the Kellogg Foundation. With the money, he established and directed a complicated, university-wide network of 13 research projects. Among other things, the projects produced a fresh set of rating concepts with practical applications for virtually all hospitals.[1] One researcher, with experience on more health field studies than she cares to admit, predicts that the McNerney findings will "shoot off more sparks than a skyrocket if the field ever gets around to reading them."

Up to now, McNerney has had little opportunity to cause fireworks in the prepayment field. His appointment as president of the Blue Cross Association changes all that. It also puts another peak on a varied career with one unvarying ingredient: extraordinary success.

After naval service as a gunnery officer aboard a transport, McNerney graduated from Yale University with eye-popping grades (straight A's, his senior year). He took his time deciding on a career. "I know I was interested in teaching, research and administration," he now recalls, "and I guess I wanted to end up being dipped in all three."

An important consideration was his desire to serve as well as manage. Thus, hospital administration appealed to him because "it provided a darn good blend of administrative challenge and community service." While he made up his mind, McNerney took a year of graduate work in economics at Yale and taught mathematics at a New Haven prep school. The attraction of community service, instilled into him from a firm New England Presbyterian background, finally won out.

"Like many others," he says, "I finally decided upon the hospital field because it provided an opportunity to make a social or community contribution in a service situation."

While the service motive may have tipped the scales, McNerney cheerfully admits that the chronology of his involvement in hospital administration was also affected by other factors — such as a blind date with a Vassar student named Shirley Hamilton. Miss Hamilton's father turned out to be James A. Hamilton, director of the program in hospital adminis-

[1] A report of this study appears on page 59.

tration at the University of Minnesota and a persuasive supporter of the graduate programs.

"If my interest in hospital administration had dropped a little," McNerney says with a grin, "it picked up after meeting Shirley."

They were married in June 1948. He started the course in hospital administration at Minnesota that summer. Next stop was his administrative residency under O. G. Pratt at Rhode Island Hospital — "a damn good hospital with an unquestionably strong voluntary motivation."

From then on he made it all look easy.

Took Two Full-Time Jobs

In 1950 he went to the University of Pittsburgh as assistant to the coordinator of hospitals and clinics of medicine. He quickly took on two full-time jobs. For one year, he served as administrator of a hospital that was shifting from state to university ownership. At the same time, he worked with Dr. Glidden Brooks in starting the Pittsburgh program in hospital administration.

Impressed with his performance and his growing reputation as a teacher and administrator, the University of Michigan tapped him in 1953 to start and direct its program in hospital administration. In a few years he also was named director of the university's bureau of hospital

"When I first began teaching, course directors had a tendency to produce little images of themselves."

"What has to be done requires a strong administrative motivation — this is a field that must be tied together effectively so that it can do its national job."

administration, which among other things does research, surveys and audits throughout the state.

Looking back on his career at Michigan, McNerney considers himself fortunate to have had a chance "to build a fairly successful program. I had a unique blend of opportunities, an enriching experience," he says, "the opportunity to teach, to manage, and to go out into the field frequently to help solve problems. It was not a typical academic situation."

Now that the programs in hospital administration are maturing, he sees definite signs that the curriculums are changing and improving.

"Because hospitals operate under close public scrutiny it is proportionally more important for them to give providers of care overt evidence that they are operating within reasonable grounds — even though the criticisms of hospitals may be on the basis of allegation rather than fact."

"When I first began teaching," he recalls, "course directors had a tendency to produce little images of themselves. This had the advantage of inspiration but the disadvantage of producing biased and incomplete students who were not equipped to examine all sides of issues."

Today, he finds, "more teaching is based on methodically gathered information such as you find in good literature and research."

As he sees it, teaching in the graduate programs should "focus on the role of the hospital in the community. The small details of institutional management," he says, "are better left for the apprentice years." McNerney believes that the academic portion of the programs "should give less vocational training and should concern themselves with never-to-be-repeated experiences," such as probing study of the political and economic forces that are shaping the role of hospitals.

No introvert, McNerney has a relaxed, informal style that is pleasant and deceptively easy going. His sense of humor is droll and quick.

"About the only thing he can't do well is tell a joke," says his wife, who ought to know. "That's because he's not much of an actor," she adds. "He's always himself."

Has Similarity to Kennedy

In conversation, McNerney has a powerful vocabulary and a confident, unhalting delivery that is vaguely reminiscent of President Kennedy. Like Mr. Kennedy, he has a certain boyish overtone to his appearance and a tendency to chop air with his hand while talking. He absorbs details easily and is plainly well organized and thorough.

"Mac doesn't get upset at problems because he doesn't get emotionally involved in them," says a former student. "He likes to be impersonal about decisions — and sometimes he overdoes it."

Although he occasionally lapses into academic argot ("I tend to conceptualize the problems broadly"), McNerney is invariably articulate and, at times, eloquent ("The salvation of the voluntary system lies in facing up to the new administrative demands growing out of our changing society rather than in viewing them as a threat or, at best, as annoying").

His writing, like his speech, is vigorous and somewhat rococo. He has been known to fight editors hard to retain his wording, which occasionally takes the long way around the barn.

As one might suspect, McNerney's aggressiveness finds a relaxing outlet in competitive sports. A fair golfer and tennis player, he is especially good at hockey, which he plays with his two older sons (ages: 12 and 11) while his two younger sons (5 and 1½) and his daughter (8) cheer their pop. McNerney also coaches a little league baseball team in Ann Arbor ("we end up second every year"), is an elder in the Presbyterian church, and a Rotarian.

At present, McNerney is understandably reticent to talk about his plans for Blue Cross. "It's unwise to go into a new job with pronouncements," he says. "I want to be darn sure I know what I'm talking about before undertaking leadership. Right now," he admits, "it would be impolitic to discuss what I plan to do — and I have no reluctance in admitting it."

In an interview, he was characteristically honest in explaining his reasons for accepting the presidency of the Blue Cross Association.

"There are a few important points of leverage in the health field," he explains, obviously suggesting that his new assignment is one of them. "The nature of the position as well as the content of what is involved is most appealing. I look upon it as a platform to do some good and an opportunity to implement many of the things that I've thought about for a long time. What has to be done requires a strong administrative motivation — this is a field that must be tied together effectively so that it can do its national job."

McNerney shrugs off suggestions that his age, or lack of it, will hinder his performance. As full professor at 32, head of a graduate program at 30, and hospital administrator at 26, he has encountered this problem before. "You get used to the idea of being young in positions and never think about it," he says.

Although McNerney now ducks questions about his plans for Blue Cross, his views are widely known. The utilization study he directed in Michigan, for example, strongly recommended that Blue Cross require all participating hospitals to conduct a continuing study of effectiveness and join the Professional Activities Study. This group collects and analyzes medical records and is sponsored by the American Hospital Asso-

(*Continued on Page* 130)

How To Save the N.L.N. Accreditation Program

The way to improve accreditation of nursing schools is not to scrap the N.L.N. program, the author argues, but to find new methods to strengthen and save it

James G. Carr Jr.

IT IS no secret that the current approach to accrediting schools of nursing bothers many hospital administrators and nurses. Obviously vigorous efforts are needed to resolve existing differences of opinion on the program.

In a sense, the current situation really is not as complex as it appears to be. Many of the differences in approach are relatively minor and can be settled without fanfare. A few major differences, no doubt, require comprehensive review. However, they hardly involve any principles so controversial that they cannot be resolved through the age-old process of discussion and compromise.

I am not implying here that the problem is not significant. Quite the contrary; it is urgent and it must be met without delay. If hospital administrators are expected to extend further patience there must be evidence that effective action will be taken to correct any shortcomings that may exist in the accreditation program and standards. It behooves the National League for Nursing to direct its energies toward a review of its program and the immediate correction of abuses that exist. If there is indication that the League will fail to meet this responsibility, it seems likely that many hospital administrators will reach the end of their patience.

Mr. Carr is administrator of Memorial Hospital, Natrona County, Casper, Wyo., and a member of the board of directors of the National League for Nursing. The opinions expressed here are, of course, his own.

Some people argue that the only way to solve the accreditation situation is to start all over again. They contend that some new agency or joint commission should assume the responsibility of accreditation. Such a change might well occur eventually, and it is possible that it may some day represent a progressive development in the field. At the moment, however, if such a change were accomplished merely to serve a vindictive purpose, or because of failure to compromise or otherwise resolve existing differences, it might well be that the new approach would accomplish little or nothing. Such a move would probably succeed in doing nothing more than transferring problems from one agency to another.

The National League for Nursing was not constituted as an accrediting agency without considerable expenditure of energy and thought on the part of organizers and supporters. It hardly appears logical to discard their efforts until it has been determined that no workable solution can be developed from them. Would it not be more reasonable to try to resolve the differences, rather than establish a new agency which may be no more effective?

There are many things that favor the N.L.N.'s continuing to handle the accreditation program. Because of its organizational pattern and its diverse and representative membership, the League can provide an impartial and competent program. Because it is independent, the League can apply evaluation methods without the implication of prejudice or pressure. Yet, it is organized in a manner that permits it to consider and act upon legitimate protests through predefined channels.

The position of the N.L.N. seems to be substantiated if one considers the purpose of accreditation. There should be broad agreement that the general purpose of an accreditation program is to establish certain educational standards and then evaluate institutions by these standards. The National League for Nursing is certainly qualified to do this. It is little wonder that an agency charged with the responsibility of serving such a purpose is subject to criticism.

The most delicate issue involved is establishing standards. To ensure a good program, where does one draw the line between requirements and recommendations? Are there any so-called "minimal standards" that must exist if an institution is to qualify? Can a method of evaluation be found that requires little or no judgment on the part of the evaluator? If not, can we obtain evaluators who will use good and reasonable judgment in all instances? These and similar questions would plague any agency conducting an accreditation program. There seems to be little justification for assuming that N.L.N. cannot solve them just as satisfactorily as can any new entry into the field.

No one would deny that an accreditation mechanism needs constant review and revision. The criteria for

An accreditation agency must have the fortitude to stand up to schools that use bluff tactics

evaluation should be regularly scrutinized in an effort to separate necessities from niceties, and to establish a concise and clear set of standards. Surveyors should be entitled to express opinions and should be encouraged to project mature judgment in the evaluation of an institution. However, they should not be selected for accreditation visits unless they exhibit considerable talent in distinguishing between minor details and major objectives. They must also be able to base their judgment on fair and objective analysis of facts rather than upon trivial or vindictive opinions.

Visitors selected by the League and persons serving on the board of review must be impressed with the need for applying reason and common sense to their evaluations of educational technics. They must recognize that proper balance between practice and theory is essential. Evaluations should not become overconcerned with abstract theories out of textbooks or ridiculous written requirements that prove little more than the school director's ability to write.

Surveyors who are unable to distinguish between practical objectives and theoretical details should be eliminated from participation in the program. Details which have little or no significant effect upon the end result should be discarded, or at most permitted to exist only as recommendations. There should be evidence that graduates are capable of providing skilled patient care as a result of both a practical and theoretical educational experience.

The League should be concerned about the philosophies as well as the educational qualifications of its evaluators. Considerable effort should be directed toward the selection, orientation and guidance of all persons involved with the accreditation process to ensure a considerate and reasonable attitude instead of a dictatorial approach.

A recent conversation with a member of an N.L.N. visitor group elicited this comment: "On our visit to ——— Hospital, I was ashamed of the person in charge of our group. She was rude and dictatorial."

This should not be tolerated. Complaints indicating attitudes of this kind should be investigated promptly and, if confirmed, the visitor should never be used again in an accreditation capacity. (Incidentally, in the instance cited, such action was taken.)

The N.L.N. wants to have a program that is equitable and deserving of acceptance and respect. Certainly, no one wants the program to fail. On the other hand, no one wants a program that lacks sufficient strength to resist the pressures that inevitably are applied.

Schools may sometimes rightfully protest accreditation findings of an invalid or even ridiculous nature, but there are many instances where schools have protested, vehemently and unfairly, rejections which they know they deserved. An accreditation agency must have the fortitude to stand up to bluff tactics.

The established channels for the resolution of legitimate criticism quite possibly have never been adequately put to the test.

Part of the purpose of the joint committee of the American Hospital Association and the National League for Nursing is to recommend and advise on matters concerning improvements in this program. This committee is composed of persons who are respected leaders in the field. It can be assumed that their opinion would carry considerable weight. Until the committee has had an adequate opportunity to function, and unless its recommendations have been ignored or rejected, it seems unreasonable to consider the establishment of a new agency. Should not a responsible committee be given adequate time and sufficient opportunity to function before it is dissolved? If and when the National League for Nursing adopts a vindictive attitude toward the suggestions of this joint committee, then it is time to consider terminating the relationship. However, such termination should not occur until the American Hospital Association's representatives on this committee have indicated that they cannot function. This certainly would appear to be the correct procedure under the existing organization. Would not any agency, even a new one, operate in a similar atmosphere?

The process of accreditation almost invariably involves criticism. As a matter of fact, one would wonder whether or not a good job was being performed if no one raised a critical voice and if all institutions subject to review professed complete satisfaction with an accrediting program. This is not meant to imply that all protests are invalid, but it is intended to imply that at least a fairly substantial proportion of criticism is quite possibly inaccurate and should be put in the "consider-the-source" category.

It is certainly the responsibility of the N.L.N. to pursue vigorously and investigate complaints and criticisms and to determine whether or not they are valid. Where the situation appears to justify corrective action such action should be accomplished at the earliest possible time. If the League fails to do this, then it should be terminated as an accrediting agency.

Much of the current difficulty can be related to the lack of effective communications between agencies and the League and between individuals and the League.

If we would just use the communication channels available to us, many of the problems could readily be resolved. The existing committee constitutes the accepted method of communication and should be used.

There is no real reason the National League for Nursing cannot conduct a practical, sound and respected program. The old saying about the frying pan is undoubtedly applicable here. Surely, it would appear much more desirable to apply energy toward the adjustment and compromise of differences than to start all over again. The means to establish a sound, equitable program are available through the joint committee in the present structure, and they should be applied and supported. ■

Salmon tone brick, gray limestone, and turquoise glass mosaic of Clarkson Hospital's new school of nursing (center) complements hospital (left) and doctors' building (right).

School of Nursing Gets Back in Business

This handsome seven-story building is Clarkson Hospital's "welcome" to the nursing students in its reactivated school

Hal G. Perrin

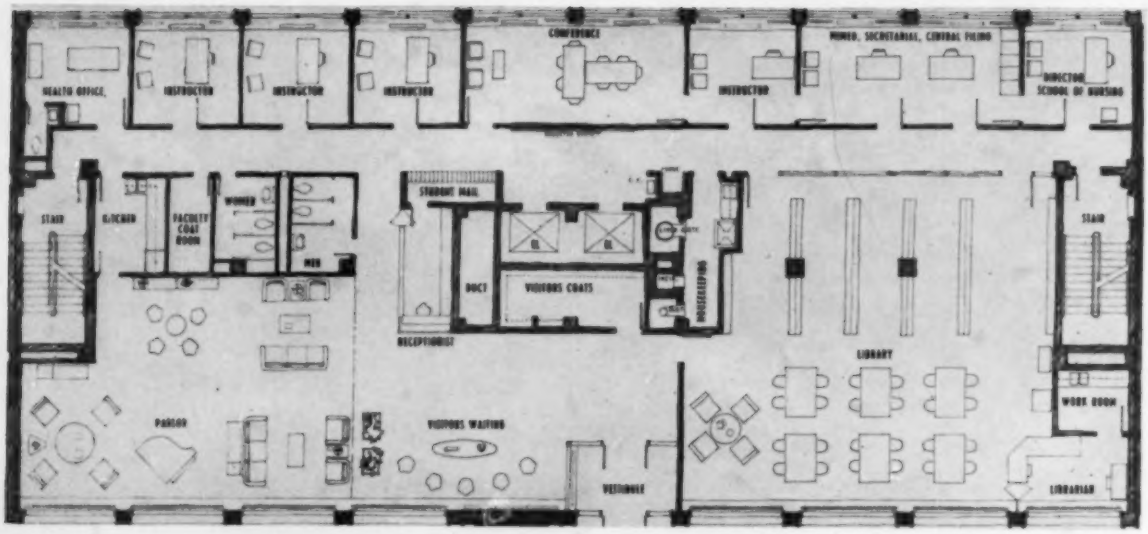
THE courses are rough but the building is dreamy," commented one of the 50 freshman nursing students who entered the reactivated school of nursing opened by Bishop Clarkson Memorial Hospital, Omaha, last September after five years of inactivity.

The "dreaminess" of the handsome, seven-story building that houses the school of nursing probably won't make the school work any easier, but it will, we believe, provide our students with a happy, livable environment in which to pursue their chosen career.

Mr. Perrin is administrator of Bishop Clarkson Memorial Hospital, Omaha.

Designed by the Leo A. Daly Co. of Omaha, architects of the new Clarkson Hospital, the school of nursing is planned to permit horizontal expansion on all levels and will accommodate 152 students. The race track plan adopted by the architects has resulted in a compact, efficient circulation pattern, so that all service facilities in the core of the building are within a few steps of the students' rooms — located on the outside of the building.

As the photographs on these pages and the cover of the magazine indicate, the students' living quarters are both colorful and functional — with dual



Students' library and a parlor for "formal" occasions occupy the largest area of the first floor of Bishop Clarkson Memorial Hospital's new school of nursing.

Total area of the seven-story building is 52,983 square feet; cost per square foot was $28.97. The building has room for 152 students plus housemothers and guests.

Below: Each dormitory floor is provided with TV lounge and snack bar where students can relax after a busy day. Bottom: Nursing practice classroom contains most of the equipment students will encounter on the nursing floors. It is usually arranged with six beds.

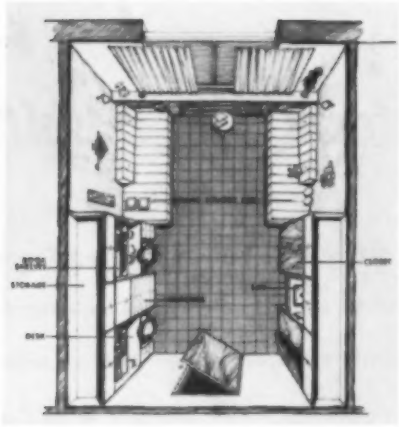
SERVICE FACILITIES

personalities. They are living rooms in the daytime and bedrooms at night. Each room accommodates two students and includes a private closet, study desk, and vanity space for each girl.

An intercommunication unit is located in each room so that any nursing student can be called for special duty or to one of the private booths for personal telephone calls.

Teaching space consists of two major classrooms, each having a capacity of 60 students, and three smaller classrooms, each of which can be divided into two smaller units for small group teaching.

Faculty staff offices, the library, reception room, and parlor are on the main level, while the large recreation area is on the ground floor adjacent to a patio that will be used for outdoor parties. The recreational area can be converted into an auditorium for 200,



Drawing shows how compact area of typical student room is arranged. Cover picture shows colorful decoration.

Efficient use of wall space provides ample living area for students at Clarkson School of Nursing

ARE AT CORE OF BUILDING WITH ROOMS ON PERIPHERY

or to a dance floor. Mechanical facilities, trunk storage, automatic washers and dryers, and linen storage take up the remainder of the ground floor.

The school is completely air conditioned as is the hospital.

Floors are rubber tile throughout. There is considerable acoustical treatment and other soundproofing in construction, making for a quiet building conducive to privacy and concentration for studying.

The reopening of the school of nursing and construction of the building (named Kiewit Hall) were made possible by the gift of more than a million dollars by Mr. and Mrs. Peter Kiewit of Omaha. The balance of the cost, including additional land, parking and tunnel to the hospital, ($2.6 million total) came from a public campaign, Hill-Burton funds, and a college housing loan. ■

Students add a decorative note to the already decorative walnut paneled waiting-reception area on the main floor. All interior colors are pastel autumn tints. Central color tone of natural beige was used throughout with accessories in accenting tones of rust, brown and gold.

How Proper Consent Protects the Hospital

In this first of several articles on legal consent, the author points out why it is important that the hospital be protected from battery suits and situations in which the hospital might be held liable

John F. Horty

BEFORE hospital care is rendered or before any medical or surgical procedure is undertaken, consent to such care or treatment must be obtained from the patient or someone authorized to consent for him. This legal rule, simple only on the surface, is the basis for the increasing concern of hospitals and physicians with the question of liability under the law of battery.

John F. Horty

If an authorization from the patient is not obtained before treatment, except in an emergency or a situation which gives rise to an implied consent, a trespass to the person is committed — a battery — for which the nonconsenting patient may recover damages. Thus, a touching of the person without consent can cause liability.

Litigation in this area is increasing. In addition there is some confusion as to what legal rules are being applied by the courts, and some misunderstanding on the part of hospitals and physicians as to what they must do in order to be adequately protected. This misunderstanding stems in part from the more stringent rules that courts are now applying to determine what constitutes valid consent.

For the next several issues, this column will discuss various aspects of what might be loosely termed the problem of consent to medical or surgical treatment and hospital care. This requires a specific discussion of what constitutes a valid consent, how such a consent can best be proved, who must consent, to what extent an emergency alters the necessity for obtaining consent, the effect of the refusal of a patient to consent, and who may be held liable if no valid consent is procured.

Since the liability of the hospital in a situation where no consent has been obtained from the patient is basic, it is perhaps logical to deal with this first. There are two main parts to this question. One concerns the liability which can be imposed upon a hospital for a battery by its agents, servants or employes; liability for a touching without consent by nurses, technicians, residents and interns. The other is the possible liability of a hospital for a battery by a member of its medical staff.

There is little question but that the hospital would be held liable under *respondeat superior* for any act of an employe that results in a battery and that occurs while the employe is discharging his hospital duties. In effect, the legal doctrine of *respondeat superior* is that the employer shall be held legally responsible for acts of his employes committed while discharging the general duties assigned them by their employer. Thus, the hospital would be held liable in damages for any act done without the consent of the patient unless it were determined that the employe, at that time, was acting temporarily as the agent or servant of someone (perhaps a physician) who was not an employe or agent of the hospital.

Under the law of battery, such an eventuality is rather unlikely. Generally, the courts have held that where an employe of a hospital is negligent in carrying out the physician's instructions as to treatment (for example, postoperative instructions) the physician will not be held to be liable. The hospital and the person who has been negligent will be held liable.

The courts generally reason that part of the service furnished to the patient, and charged for by the hospital, is the assistance of nurses, interns and attendants in caring for the patient pursuant to the physician's instructions. In so doing, they perform the duty their employer owes the patient — to furnish hospital care. The fact that the physician specifically designates an employe to carry out his instructions does not change the existing master-servant relationship between the hospital and the em-

John F. Horty is director of the Health Law Center at the University of Pittsburgh. This is the first in a series of articles on consent that will appear in this column.

Hospitals Are Feeling the Weight of More and More Legal Liability

HOSPITALS and other charitable institutions will have to learn to live with "universal responsibility for carelessness in activities by their agents and employes."

This was the view expressed by one legal expert, New York Attorney Emanuel Hayt, in addressing the American Medical Association's medicolegal symposium.

Theories once advanced to justify the charitable hospital immunity are being criticized by both the courts and legal scholars, he said, pointing out that in recent months Michigan and Wisconsin have "succumbed to the tide of abrogation of hospital immunity."

Among the theories he cited as becoming outmoded are: (1) Protection of the hospital's trust fund; (2) the inapplicability of *respondeat superior;* (3) implied waiver; (4) governmental function, and (5) public policy.

The need to provide expanded hospital services has brought about increased possibilities of error in treatment of the patient, and court decisions reflect the increasing number of lawsuits based on alleged malpractice of hospital medical and nursing personnel, Mr. Hayt said.

Referring to the many tasks now performed by paramedical personnel, he said, "It is no longer a question of whether or not the hospital is responsible for accidents to the patient, but whether the institution has assumed direct legal responsibility for injury to the patient arising out of any careless act on the part of its employes, whether medical or otherwise." ■

ploye. This rule would also be applied to a battery committed by a hospital employe in caring for a patient, despite the fact that he was following the express instructions of the patient's physician.

It should be remembered that there is a considerable difference between a battery and a negligent act, both of which are civil wrongs and both of which can cause an injury for which a patient can recover damages. The basic difference is that a negligent act is done unintentionally, while a battery is an intentional act. Negligence betokens carelessness, a failure to use that degree of care that the law requires to be used under the circumstances. It is the carelessness which causes the injury. A battery is an intentional unauthorized touching. Consequently, it is of no importance that the act (perhaps an unauthorized operation) was done with great care and actually improved the state of health of the patient. The fact that it was unauthorized makes it a battery.

While there are many cases dealing with batteries of patients by physicians and surgeons, few of these cases directly involve a hospital. However, there are clearly many circumstances where a hospital may have a potential liability.

In a *North Carolina* case a patient was operated upon by the assistant resident in surgery, an employe of the hospital. The patient contended that the operation was totally without his consent. The operation was not performed in the presence of, or subject to the control of, a staff physician. The court held that if the resident did in fact operate without the consent of the patient, liability would be imposed upon the hospital; for, under the evidence given in the case, the resident was at all times an agent, servant and employe of the hospital and was acting within the scope of his duty as such agent.

In a *California* case, several medical students and interns conducted repeated internal examinations on a female hospital patient without her consent and despite her protests. The court stated that the hospital would be liable to the patient for permitting unlicensed students to experiment upon her and to treat her without her consent.

Thus, it is clear that the liability of the hospital for batteries committed by its agents and employes includes the actions of medical personnel, such as interns and residents, as well as nonmedical personnel, such as nurses, aides and technicians.

The hospital's liability would also extend to a battery committed by a licensed physician who was an employe of the hospital. Not only can this liability arise for unauthorized acts performed during or after a medical or surgical procedure, but also for an unauthorized touching during routine hospital care.

Two possible exceptions to this liability exist. There are times during a medical or surgical procedure when the hospital employe (such as an operating room nurse) may be deemed to be under such complete and direct control of the operating physician that the employe is considered to be a "borrowed servant."

Under the legal rule pertaining to "borrowed servants," an employe may be loaned to another person for some special purpose, so as to become, for that purpose, the servant of the other.

(*Continued on Next Page*)

Usually a hospital would not be liable for more than nominal damages if actual injury cannot be shown

(*Continued From Preceding Page*)
When this occurs, the original master is relieved of the usual liabilities for the acts of this servant which are performed while he is a "borrowed servant," and these liabilities are imposed upon the temporary master. Thus, there are times in the operating room where a nurse might be under such complete control of the operating physician that any battery she might commit would be the liability of the physician.

Another possible exception to the liability of a hospital for batteries committed by its employes might occur where a patient may be deemed to have consented to routine hospital care by the voluntary act of entering the hospital for treatment. Consent to certain routine hospital care could be implied from the act of asking for admission to the hospital, even though the patient gave no written or oral consent.

Usually a hospital would not be held liable for more than nominal damages if the patient cannot show an actual injury from the unauthorized touching. In a *California* case, the patient specifically prohibited the use of a spinal anesthesia during an operation. Nevertheless, it was used. When suit was brought, the court permitted only nominal damages because no actual damage was sustained. However, some courts have allowed a substantial recovery despite the fact that the results of the unauthorized procedure proved beneficial to the patient, indicating that pain and suffering constituted a proper element of damages.

A hospital risks a substantial verdict against it when a surgical patient is given preoperative anesthesia by a hospital employe pursuant to the direction of a physician. If the patient has not, in fact, consented to the operation, and can show that he would not have consented, the act of the hospital's employe in rendering him unable to object further could well subject the hospital to full liability for the unauthorized operation. This is an instance where the hospital should be certain that a valid consent has been procured.

Where a battery is the act of a physician on the medical staff of the hospital, but not a hospital employe, or where a hospital employe commits a battery while under the complete control of a physician, so that he is a "borrowed servant," the hospital would not be liable under the doctrine of *respondeat superior*. Any liability of the hospital would be predicated upon a duty to police its premises in such a way as to prevent a battery from occurring in the hospital. This duty might be based on the theory that a hospital, by admitting a patient, must act reasonably to prevent him from being harmed. And, if the hospital knows, or should know, that a battery is taking place on its premises and does nothing to prevent such a battery, the hospital then becomes a party to the battery.

In a *New York* case, a hospital was held not liable for an unauthorized surgical operation since the physicians involved, although procured by the hospital, were not agents or employes of the hospital, whose acts could be attributed to the hospital. Thus, in this instance the hospital supplied its facilities without notice of a contemplated wrong, because the patient said nothing to a hospital employe that would put the hospital on notice. However, the court stated that it could conceive of cases where the patient's struggle or outcries, in the effort to avoid an operation, might be such as to give notice to the hospital administration that the surgeons were acting in disregard of their patient's commands. In such circumstances it could well be that by permitting its facilities to be used for an unauthorized operation, the hospital would make itself a party to the battery.

It would seem, however, that the hospital's duty should arise, if at all, only in those situations where it has or should have knowledge of the patient's objection to the medical or surgical procedure, or in situations where the patient himself is legally or physically incapable of consent. Thus, the crucial element of this duty on the part of the hospital is the knowledge that a medical or surgical procedure is to take place without the consent of the patient or someone legally authorized to consent for him. In all cases, hospitals could avoid liability by stringent administrative requirements that consent from the patient be procured in such a form that it can be proved at at a later date if necessary. Consent should be procured from the patient upon his admission to the hospital, or as soon thereafter as possible.

Satisfactory ways of procuring and proving consent will be discussed in succeeding articles. ■

Hospital Group Issues Legal Consent Manual

A USEFUL compilation of information on legal consents has been prepared by the Hospital Association of New York State.

Entitled "Manual of Therapy Consents and Legal Forms," it includes chapters on treatment of adults and minors, emergency treatment, ambulance service, blood transfusions, blood tests for alcoholic content, circumcisions, artificial insemination, therapeutic abortion, and sterilization operations.

The manual was prepared by Counsel Emanuel Hayt and Associate Counsel Jonathan Hayt to answer the many inquiries on the subject coming to the Association, according to *Hospital Forum*, the Association newsletter.

Included are pertinent legal decisions and statutes pertaining to the subjects covered, as well as 31 model forms.

Copies may be had for $1 plus postage by writing to the Association office, 11 North Pearl Street, Albany, N.Y. ■

To make this hospital truly a center of health care, the planners incorporated a wide range of diagnostic and therapeutic services for the mentally and physically ill

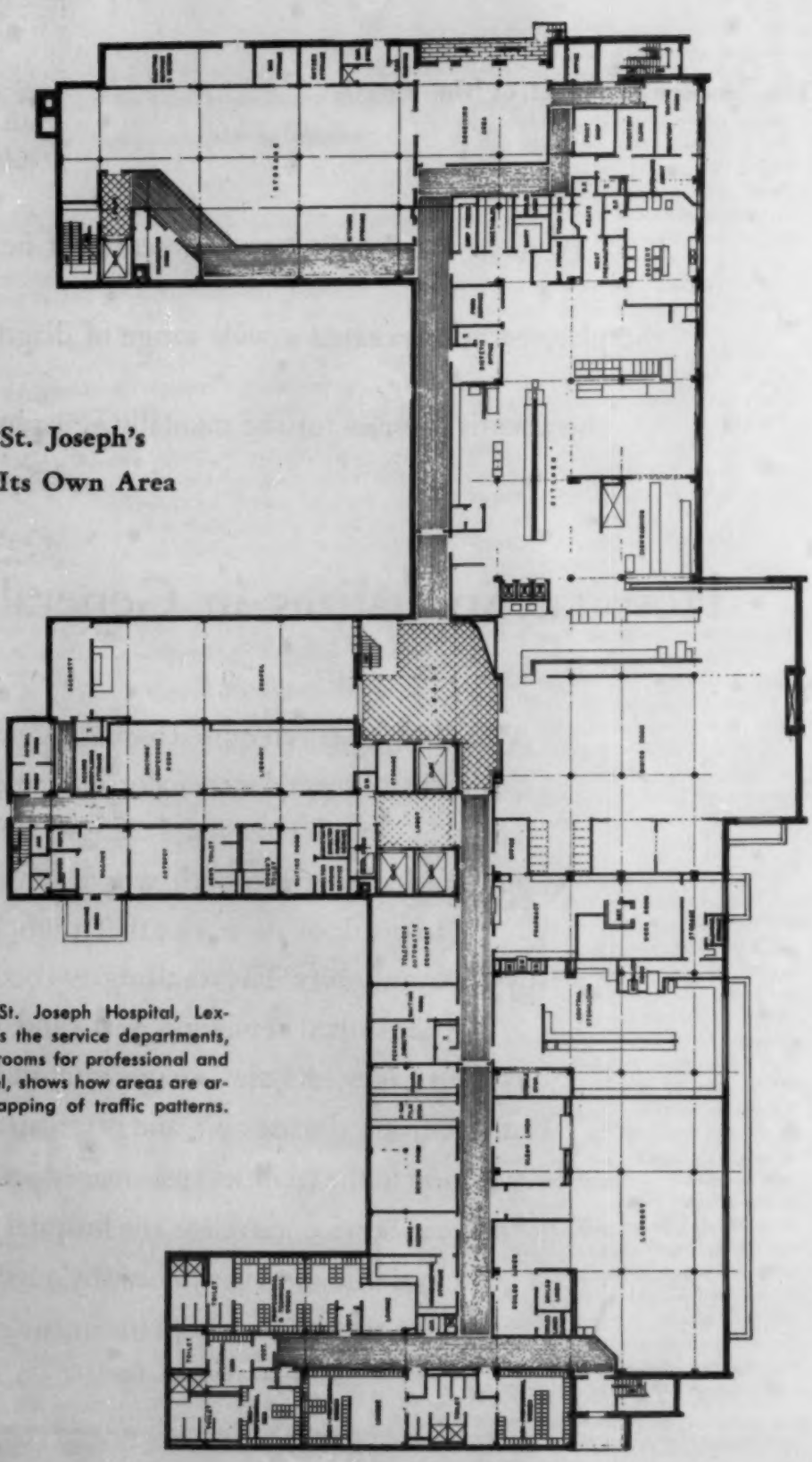
Hospital Specializes in General Care

ALL the elements required to make a general hospital truly general were incorporated in the new St. Joseph Hospital, Lexington, Ky., by the Sisters of Charity of Nazareth, who were determined to overlook no service that might be needed by the community. The resulting 294 bed hospital, described in pictures, plans and text on the next four pages, includes a diagnostic and treatment center, chronic disease unit, and psychiatric wing, in addition to the facilities customarily provided. To make its service complete, the hospital maintains close affiliation with a near-by nursing home. While all services except the nursing home are

(Text Continued on Page 76)

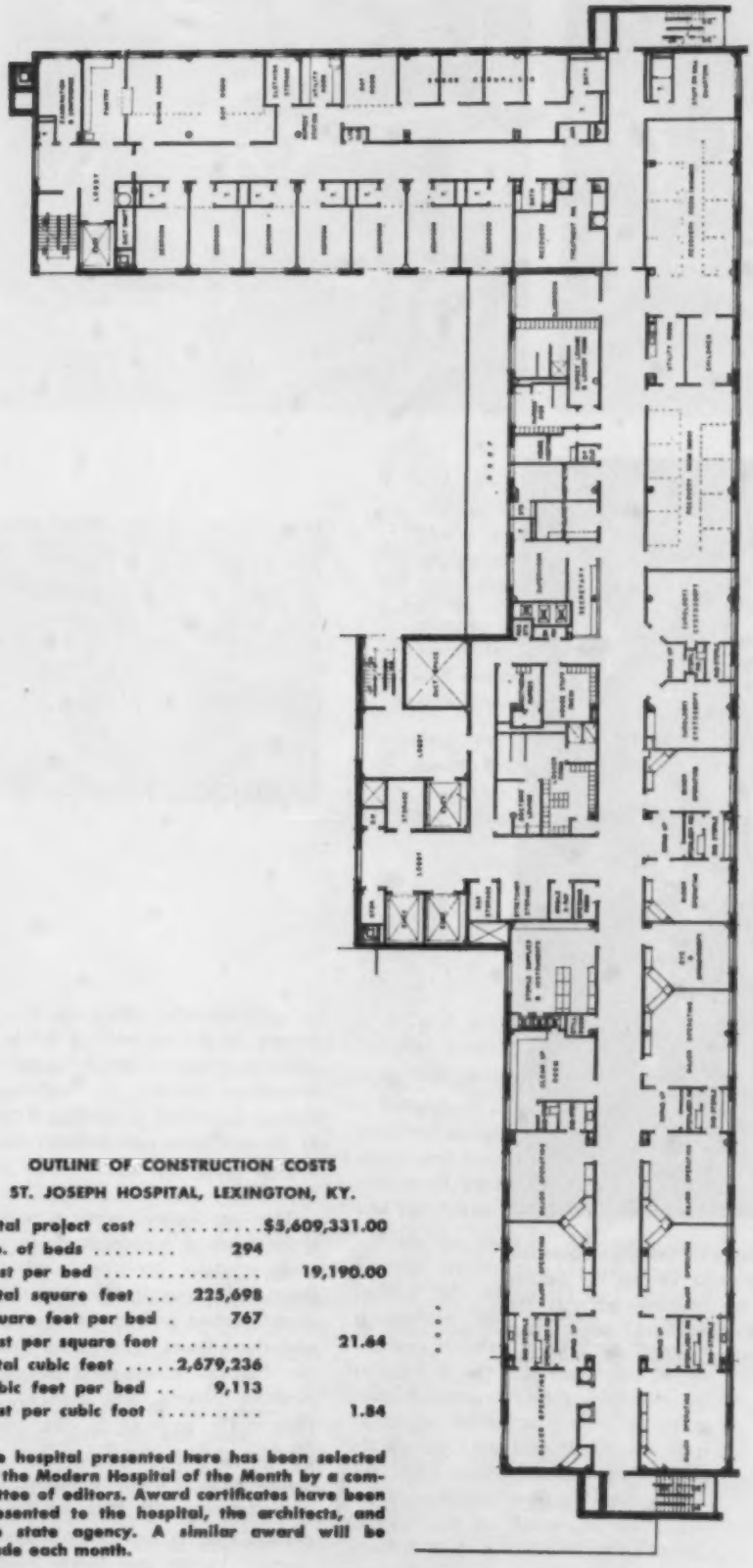
Architect of St. Joseph Hospital was George Roth of the firm of Potter, Tyler, Martin and Roth, Cincinnati. Elizabeth D. Simmerman of Cincinnati was hospital consultant. Sister Margaret Theresa is the administrator.

Each Service at St. Joseph's Is Contained in Its Own Area



Plan of ground floor, St. Joseph Hospital, Lexington, Ky., which houses the service departments, dining area, and locker rooms for professional and nonprofessional personnel, shows how areas are arranged to prevent overlapping of traffic patterns.

All photographs by George Stille, Cincinnati



St. Joseph Hospital from the front (top) and rear. The ambulance entrance leads into emergency operating rooms and a separate admitting lobby.

Second floor (left) of the hospital proper is devoted to the surgical suite and recovery rooms. Psychiatric patients are in the wing of the building.

OUTLINE OF CONSTRUCTION COSTS

ST. JOSEPH HOSPITAL, LEXINGTON, KY.

Total project cost		$3,609,331.00
No. of beds	294	
Cost per bed		19,190.00
Total square feet	225,698	
Square feet per bed	767	
Cost per square foot		21.64
Total cubic feet	2,679,236	
Cubic feet per bed	9,113	
Cost per cubic foot		1.84

The hospital presented here has been selected as the Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

In keeping with the plan to make St. Joseph's a center for health service, the hospital includes an extensive outpatient department with waiting area for patients.

Psychiatric Patients Occupy Separate Wing

(Continued From Page 73)

housed in the seven-story brick and concrete structure, the architects and consultant planned the building so that each service is neatly contained in its own area and patients in one division have no occasion to enter any other.

The psychiatric service occupies three floors of a separate wing, with the outpatient services on the first floor and rooms for disturbed and semidisturbed patients on the second and third floors. The fourth floor of the hospital is assigned to general medical patients, and beds for psychosomatic patients in the psychiatric wing flow into the general area.

The surgical suite, including 13 operating rooms with their ancillary facilities, two recovery rooms, and the doctors' lounge and locker room, is

Above, left: Ice cream parlor chairs and white wrought iron grillework lend a touch of the "Old South" to the cafeteria.

Above, right: Typical private room for patients. All rooms are equipped with built-in storage space, toilet and lavatory.

Employe in the central kitchen on the ground floor rolls a food cart with patients' trays onto the floor-level dumb-waiter.

located on the second floor. The majority of rooms for surgical patients are directly above this area on the third floor.

Maternity beds, labor and delivery rooms, and the nurseries are on the fifth floor, while pediatric patients have their own special unit on the sixth. This floor includes an isolation unit, a schoolroom and playroom, and 10 of the 50 chronic disease beds. Hospital officials believe children suffering from long-term illness should be with other children rather than with adults.

The rest of the chronic disease unit, including dayroom and dining room, is on the fifth floor. To meet the special needs of the aged and infirm patients, bathtubs in this section are set low and handrails line the corridors.

A large recreational area on the hospital grounds is available to all long-term patients.

Patients in all divisions are accommodated in private and semiprivate rooms and four-bed wards, each room and ward equipped with a lavatory and toilet area.

Both the interior decoration and exterior construction contribute to a feeling of lightness and airiness throughout the building. Glass-enclosures at either end reveal stairways painted in aquamarine, with bright coral banisters. This combination of colors in varying intensities is carried all through the hospital. Floor, wall and equipment surfaces were selected for their durability and scrubability: ceramic tile on floors and walls, enameled steel on cabinets and fixtures, marble and glass in the lobby. ■

Blue Cross and Insurance Commissioners Agree on Most Questions of Reimbursement

BLUE CROSS officials and state insurance commissioners have their differences, but on most questions of hospital reimbursement they are in accord.

This is indicated by replies from 71 Blue Cross executives and 33 commissioners to a questionnaire survey conducted by the National Association of Insurance Commissioners.*

The first point on which Blue Cross officials and insurance commissioners recorded substantial agreement is that when two or more Plans exist in the same state they should use the same formula for hospital reimbursement. The respondents also agreed that, desirable as this standardization may be, it is not customary in most areas. Only four commissioners and five Plan officials (from states in which the question was applicable) reported that two or more plans within a state use the same formula.

The majority of both groups believe that a Plan's reimbursement formula should be the same for all hospitals within its area of operation and that the formula should be flexible enough to recognize the characteristics and needs of particular types of hospitals. There was less agreement as to whether the formula should be sufficiently flexible to permit negotiations with individual hospitals to meet specific needs of the hospital. Although 18 commissioners and 44 Blue Cross officials agreed that it should, 12 commissioners and 24 Blue Cross officials apparently think this is carrying flexibility too far.

The majority of insurance and Blue Cross executives believe that payments should be made to nonaccredited hospitals but they part company on the question whether the reimbursement formula for these hospitals should differ from that used for accredited hospitals. Most insurance commissioners think it should; most Blue Cross officials think it should not.

There is virtual unanimity in both groups that hospitals should be subject to review to guard against excess utilization; 29 insurance commissioners and 68 Blue Cross representatives voted Yes on this question. However, the respondents gave a variety of answers to the question: "What type of agency should make this review?"

The same number of insurance commissioners (7) voted for a utilization committee of the hospital medical staff as for a joint committee representing hospitals, physicians, Blue Cross, and the public. Among Blue Cross Plans, the vote was 27 in favor of the hospital medical staff and 19 in favor of the joint committee. Other review agencies suggested were: health department or other state agency; Blue Cross physicians review committee, and medical society.

Audited hospital costs offer the most satisfactory method of hospital reimbursement for Blue Cross operations, in the opinion of both state commissioners and Plan officials. This method is preferred by 32 Plans and 15 insurance officials because audited costs are "equitable, flexible and promote uniformity of accounting and controls." Also, in the opinion of 16 insurance commissioners and 31 Blue Cross representatives, audited costs provide the greatest incentive for economical hospital operation. Of the other possible methods of reimbursement suggested in the questionnaire (flat per diem negotiated fee; sliding scale per diem negotiated fee; charges as billed to patients; discounted amount of charges billed to patients, and costs subject to a ceiling) the last received the second highest number of votes (27) from Blue Cross officials. Only four insurance commissioners voted for it. The proponents of this method of reimbursement prefer it because it "offers protection against excessive charges." The objections to the audited cost method of reimbursement and the costs subject to ceilings were that the former does not penalize inefficiency and is difficult to determine and the latter complicates administrative problems.

Whether there should be floors and ceilings under and over reimbursements is cause for considerable debate not only between commissioners and Blue Cross but within each group.

For example, 15 commissioners voted Yes on the question: "Should there be a floor on per diem reimbursement?" and 14 voted No. Among Blue Cross officials, the vote was reversed: 19 are for a floor; 42 are against it. The majority of insurance commissioners also want a ceiling (23 for, 7 against) and so does a majority of Blue Cross representatives.

No consensus was reached on how a ceiling could be used to deter poor administrative practices without affecting the quality of care.

Another question that came out almost in a tie was whether quality of care should be reflected in the reimbursement formula, aside from the cost of such care. The insurance commissioners are evenly divided on this one: 15 think Yes; 14, No. Blue Cross officials, too, are divided in their thinking – but in reverse. Twenty-seven voted Yes and 33 voted No. Blue Cross officials are almost solidly (65 to 2) against the idea that a public agency, such as the state health department, should establish ceilings for hospital charges, whereas some of the state insurance commissioners are in favor of it. The majority of commissioners who answered this question, however, join the Blue Cross officials in opposing it.

The last 17 questions covered in the study were presented on the assumption that the reimbursement formula was based on cost. The respondents were queried as to whether such a formula should: (a) make provision for capital to purchase expensive medical equipment; (b) make provision for capital to purchase "labor saving" office machines; (c) require that the cost of extensive hospital repairs be spread over more than one year; (d) include an allowance for depreciation. On all four of these questions insurance commissioners and Blue Cross officials were largely in agreement, with the majority voting in favor of these provisions.

The sharpest difference of opinion between insurance and Blue Cross officials was recorded on the question: "Should Blue Cross be charged with the salaries and expenses of hospital personnel devoting their time to collection of outstanding accounts?" Blue Cross officials voted 51 to 9 in favor of accepting this charge while insurance commissioners opposed it by a vote of 20 to 11. ■

*National Association of Insurance Commissioners, subcommittee to study the problems of reimbursement formulas between hospitals and nonprofit hospital service associations. Commissioner F. Douglass Sears, Maryland, was chairman.

How Doctors Solved the Shortage of Interns

Faced with a shortage of interns and residents, attending physicians at this hospital met the crisis by taking on the house staff duties themselves

Jay W. Collins

THE medical staff at Euclid-Glenville Hospital, Euclid, Ohio, faced a stiff test along with residents and interns who were examined recently by the Educational Council for Foreign Medical Graduates.

As a result of the E.C.F.M.G. testing program, the hospital's resident and intern staff was reduced from 20 doctors to seven. Although a house staff shortage had been a problem for many years at Euclid, the recent testing program threatened to turn it into a crisis.

We Faced These Problems

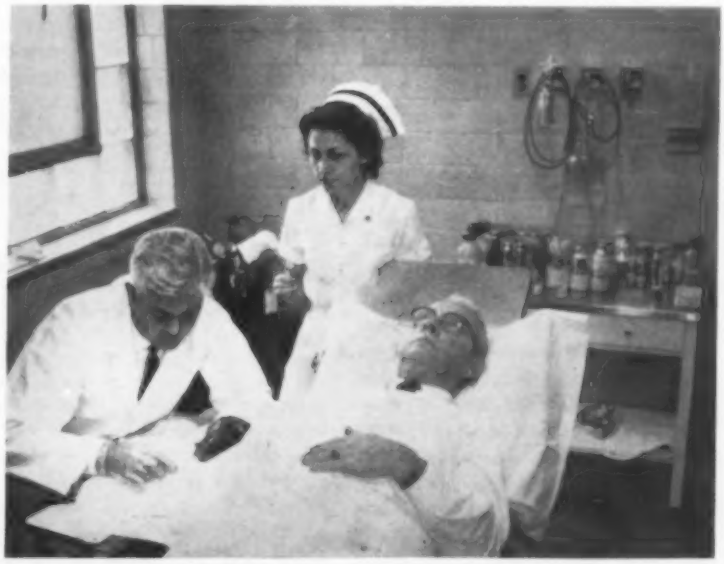
Here are some questions we faced, along with hundreds of other hospitals, when the supply of foreign medical graduates was drastically reduced:

What happens to patients who have had their illnesses carefully studied by interns and residents, who have had a corps of operating room aides assisting their surgeon, who have been attended during labor by young physicians? What of the hundreds who come to the emergency room every week expecting immediate attention?

And what of the physicians whose practices are geared to having competent, reliable helpers observing and treating their patients? Instead of two to four hours a day at the hospital, were they now to be in attendance four to 10 hours? If so, what happens to the patients needing office attention or those in other hospitals?

As a first step, we held several meetings of staff members and officers to discuss possible ways to alleviate the shortage. The doctors decided that doubling or tripling salaries of house physicians was not the answer. They satisfied themselves that the quality of the training program was not the reason for the shortage, and that there was little room for improvement in this area. They thrashed out the possibility of hiring full-time assistants, but decided that this would be a shaky and not too desirable solution since such persons are available infrequently.

Finally they said, in effect, "The only way we can preserve the standard of care we feel our patients should have is to do the job ourselves, with such help as our house officers can



Dr. V. T. LaMaida, chief of staff, is shown at work in an emergency room, his duty station for the night. Staff may be asked to serve on emergency, medical or surgical service, depending on their special qualifications.

Jay W. Collins (the man in the dark suit) consults with members of the medical staff of Euclid-Glenville Hospital, Euclid, Ohio, on an acute staffing problem, which he describes in this article. Mr. Collins has been executive director of the hospital since 1947 and has served as an officer and trustee in state, local and national associations. Along the way he has gathered several awards for distinguished service to his profession.

render without interfering with their training program."

This is what we did:

First, we determined how much additional help was needed and of what types. This involved rechecking the duty load of interns and residents. This study resulted in the installation of a central dictating system with units throughout the hospital so that attending physicians can dictate the histories, physical examinations, and discharge summaries of their patients. It also resulted in comprehensive night coverage of the laboratory so that physicians on night call would not have any laboratory procedures to do. We already had 24 hour x-ray coverage, so no change in that department was necessary.

We did not want our house staff to be on call oftener than every third night. With a resident staff of seven house officers, it was apparent that only two could be on duty each week night. Our standards however, called for four to be on duty — one was needed for medicine, one for surgery, one for obstetrics, and one for emergency room. This made it necessary for us to have two attending physicians on duty each night to supplement the regular house staff.

The medical staff executive committee faced this problem squarely. It decided that every night one obstetrician and one other staff member should be on duty.

The obstetricians developed their own roster. They agreed to take night call about once monthly since there are about 30 OB specialists on our staff. Their duties are the same as if they were obstetrical residents.

For the rest of the staff, the rotation was more complicated. The most elderly men were excused, though some subsequently volunteered to take a regular turn. Seldom-seen consultants were excused, as were courtesy staff physicians who rarely admitted patients. All other doctors, except those with health problems, were put on the call roster.

Select Their Own Duty

Obviously, an ophthalmologist would not make a very good resident in internal medicine, and a radiologist or pediatrician wouldn't be too proficient in surgery. The solution here was to let each attending physician select his assignment when he came on duty at 6 p.m. Normally a physician in one of the medical specialties chooses to be on medical duty, leaving the medical resident in the emergency room and the surgical resident in surgery. The reverse is true of physicians within the surgical specialties. The attending physician on call is backed up by the other doctors on duty and by the patients' physicians, who may be reached by telephone. In addition, when covering the emergency room he has a comprehensive roster of specialists who are "on call" for service cases.

Somewhat to their surprise, practically all of the doctors have enjoyed this extra responsibility — although none hopes it is permanent. A few have been concerned with public reaction to their assuming a lower status, and many have had to cancel office hours or change personal plans when the roster was published. But no one has refused to do his share.

These plans, developed by the staff executive committee, were submitted to the active staff, where approval was readily given. In fact, the active staff passed an addition to the rules and regulations which stated that staff membership is dependent upon willingness to accept special assignments.

The board of trustees accepted the staff recommendations and passed a resolution of commendation for the staff.

Naturally there were many administrative ramifications to this matter. The primary one was to assist the staff in its initial soul-searching, but not to attempt to lead them to the solution. Clarifying their legal status was also an administrative function. (The attending physicians, when acting as night residents, are agents of the hospital but have personal liability as well.) Providing sleeping quarters and making refreshments and laboratory coats available were other simple details. Publication of rosters, far in advance, was another essential detail.

There are many pros and cons to the solution we have found. The biggest "con" is that no one wants this arrangement to be permanent. One "pro" is that the entire staff is now active in recruitment of interns and residents, rather than leaving that duty to one committee.

One lesson we learned was that it would be folly to *tell* the doctors how much time they should give. If giving of time is the answer they will determine that themselves, for dedication to the best interests of patients is still a basic attitude of physicians. ■

Education program gives school children an understanding of the hospital's place in their lives

For cufferies kings had been swindled by this beast without ever thinking to check the efficiency of the horn. Paré was the first we know of to try it and find out.

Upon Paré's request, the king sent for a condemned criminal who was about to be executed. The criminal was told that he could have his choice: either be strangled in the old-fashioned way or take poison mixed with the Unicorn's horn. If the Unicorn's horn prevented the poison from killing him, he could go free. This wasn't much of a choice really and the criminal took the poison. It is believed, from Paré's description, that the poison was mercury bichloride, sometimes called corrosive sublimate.

For about six hours the condemned man writhed in agony while the poison corroded his stomach. Before he died he cursed Paré, the king, and the Unicorn's horn and said that if he had known it was going to be like this he would have chosen strangulation.

You might think this would end the Unicorn's horn as a remedy, but it did not. For many years afterward physicians continued to peddle the Unicorn's horn. Their answer to Paré's experiment, if they had heard of it, was simply that Paré was a liar. Of course, they never thought to check for themselves.

If Paré had really been a thorough scientist, he would have run many more experiments with other poisons and other criminals. All he had proved by this one experiment was that Unicorn's horns do not work every time. He still hadn't proved that it didn't work most of the time or some of the time. The important thing, however, was that he was one of the first in history to check at all by actual trial. He was one of the pioneers of modern experimentation. His work was not measurement, as we commonly use the word today. But if we expand the term measurement to its broadest meaning of "judgment by comparison with something else," then he was actually measuring beliefs about Unicorn's horns with actual reality.

Paré owed much of his skill as a surgeon to a man named Andreas Vesalius, who performed another sort of measurement. Vesalius was the first great anatomist of modern times. He published *De Humani Corporis Fabrica* (the structure of the human body), a book that showed for the first time in accurate detail outlines of the muscles, tendons, and vessels in the body. Vesalius took his measurements directly from the dissecting table and pioneered the way for the study of medicine from life itself.

UNICORN'S HORN

The first was Ambroise Paré, a famous French physician who lived during the middle of the sixteenth century. Paré was one of the very few physicians of his time who doubted the value of some of the old nostrums. One famous remedy that he questioned was Unicorn's horn. This was supposed to be an antidote for all kinds of poison. Unicorn's horns were very rare, of course, since no one had ever seen a unicorn (a horse with a horn in the middle of its forehead) and kings, who were always afraid of being poisoned, paid great fortunes for the horn. Modern writers believe the horn was actually either carved out of ivory or taken from a rhinoceros or narwhal.

There were two schools of thought about the Unicorn's horn. One said the best way to take it was in powdered form mixed with the drink. The other school argued that Unicorn's horns were very hard to get and shouldn't be wasted. The horn should be hollowed out and used as a cup. That way it would last indefinitely.

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Page from the text for sixth to eighth grade pupils, which teaches them to construct various medical instruments.

Iowa Takes Hospital Story to School

IF THE school children of Iowa, and 11 other states, don't grow up with a better understanding of hospitals and their importance to the community than their elders have had, it won't be for lack of education.

"In Quest of Health," an educational program devised for school children by the Iowa Hospital Association in its quest for public understanding, is now being studied by 60 per cent of the school population of Iowa, according to James A. Anderson, chairman of the association's council on education and administrator of Lutheran Hospital in Fort Dodge. In addition, materials are being distributed to schools in Minnesota, Missouri, Alabama and Ohio, and the hospital associations of seven more states have adopted the program officially and are preparing to present it to their schools.

Genesis of the program was the need felt by the Iowa Hospital Association to overcome public indifference and, in some instances, downright antagonism to hospitals.

"The image of the modern hospital leaves something to be desired," it is explained. "There are many pragmatic reasons *why* the hospital story must be told. . . . The answers to the question of *how* lie in 'In Quest of Health.'"

The logical place to start telling the hospital story, it seemed to Mr. Anderson and the other council members, is in the schools.

"Today's labor leaders, hospital trustees, and politicians were yesterday's students. Just as surely, today's students will be the labor leaders, hospital trustees, and politicians of tomorrow. . . . Exquisite care should be taken to make them knowledgeable about our hospitals and their relationship to the American way of life," they point out.

The teaching materials include a teacher source book, four textbooks (each addressed to a different grade level), and wall-mounted teaching charts that highlight the topics covered by each manual.* The contents of each of the manuals are summarized briefly in the panel on page 83.

"In Quest of Health" makes a distinct contribution to education, the

*Educational materials for "In Quest of Health" were prepared by Paul S. Amidon Associates, Minneapolis, educational consultants.

The history of medicine from medieval times to present is spanned in manual for fourth, fifth and sixth graders.

Economics and sociology as they relate to hospitals are woven into the manual for the senior high school students.

PROGRAM IS DISTRIBUTED TO

hospital authorities feel, by enriching the teaching of history, science, social studies, and economics.

Distribution of the program is effected by the state hospital association through the local hospitals.

In Iowa, the central office of the association handles the entire program, and distribution rights have been retained by the association. Local hospitals sponsor the program in their own communities, thus assuring successful utilization of the materials by the schools. When a hospital advises the state association of its interest in the program, the association requests the educational consultants to get in touch with the schools in that community and enlist their interest in putting the program into the school curriculum. When the school's approval has been granted, the local hospital is billed approximately 3 or 4 cents per patient day to cover the cost of the instructional materials.

The speed with which the program, introduced in Iowa in 1959, has caught on in widely separated sections of the country (from Virginia to California and from South Dakota to Florida) indicates to Iowa hospital leaders that their idea of instilling an understanding of hospitals in children

How 'In Quest of Health' Tells the Hospital Story

Instructional materials used in the Iowa education program consist of a teacher source book, four manuals directed to students of various ages, and four wall-mounted charts — each of which is related to one of the manuals. Following is a brief summary of the information contained in each manual.

Teacher Source Book. This guide manual, covering all 12 grades of elementary and secondary education, explains the role of the hospital in community life. An overview chart lists concepts to be taught and correlates these concepts with topics found in most curriculum lists. Careers in the medical, paramedical and hospital fields are also described.

Joey's Journey (Grades 1, 2 and 3). This unit begins the process of familiarizing very young children with the hospital. Community helpers in the persons of nurses, technicians and others in the hospital make the story seem real to the pupils and help allay their fear of the hospital.

Doctor Schnabel (Grades 4, 5 and 6). The historical development of hospitals is dramatically told as the central character, Doctor Schnabel, contrasts health care facilities of medieval times with those of the Twentieth Century.

Measuring Health (Grades 7, 8 and 9). An actual hospital case history is used in this manual to show the application of many instruments and large pieces of scientific equipment common to most hospitals. The scientific method of problem-solving is explained and taught in practical terms. The students learn to construct a manometer, a microscope, and the simple Galileo thermometer.

The Anatomy of Health Services (Grades 10, 11 and 12). These teaching materials for students on the high school level are based on problem-solving as the stated problems relate closely to the narrative providing the facts. Personal contact between students and community leaders is required as answers are sought by students for the problems presented. The hospital, as a basic community component, is related to economics and social necessity, and the prepayment insurance plans and their relation to the voluntary hospital system are explained in detail. An occupational guide has been included in this manual on the assumption that the students may be interested in a hospital career.

Teachers manual and four textbooks provide instructional materials for Iowa program on hospitals' role in the community

SCHOOL SYSTEM BY THE LOCAL HOSPITAL

of school age is sound. And they can already see evidence of greatly increased interest in hospitals in communities that are using the program.

School officials, teachers and children have indicated their growing interest by using the hospital as a destination for field trips or as a point of reference for "projects."

When the program was first introduced, it met with opposition from the Iowa State Medical Society, partly because some doctors thought some of the teaching materials were "undignified," and partly because of a feeling that in sponsoring so broad a program of health education, hospitals were reaching out beyond their proper function in the community. Since the program has been operative, however, opposition on the part of physicians in Iowa has largely vanished, association officials state.

Mr. Anderson and his associates are proud of the fact that every school that has undertaken to use the "In Quest of Health" program has maintained its interest and shown no intention of dropping it. It is important, they believe, for the sponsoring hospitals to continue the program for at least the next five years. ■

A successful person is likely to be
the one who has been most successful
in avoiding these roads to failure

LEARN HOW TO FAIL—

D. M. Harrison

ALL our lives we have been taught what to do, what to study, how we should think, what jobs would be best suited for us, and many other requisites for success.

Has anyone taught you that one of the best ways of succeeding is by knowing the requirements for failure?

There are many paths to failure, and it is difficult to determine which is the best. If an employe can learn and define the ways of failure and take advantage of the knowledge gained, he will usually reach his ultimate potential and objective.

Let's consider a few examples of how to fail:

1. When your supervisor asks you to do a particular duty, explain to him the many reasons why it can't be done.

Conduct an extensive search into hospital regulations to find something to back you up. Be sure to smile when you show the substantiating evidence to your supervisor. This will convince him that you have familiarized yourself with regulations.

2. Constantly remind your supervisor that you have been assigned too much to do, and that he

Mr. Harrison is assistant manager, Veterans Administration Hospital, Montgomery, Ala.

Never Settle for Less Than the Best

THE manager has a responsibility to the people working with him. He has the responsibility to build the structure in which men can achieve the most, and to find the right spot in the structure for each of the professional specialists. He must make most effective whatever skill and knowledge the specialists have, and give full scope to their judgment. He has to keep them informed of the common goal toward which their efforts are to be directed; and he has to keep himself informed of the new potentials of contribution and performance opened up by advances in areas of specialized knowledge. He has the responsibility to create, in other words, the conditions in which the professional specialists can both achieve the most and develop themselves the most. And he has the responsibility — both to the individual and to the organization — to demand superior performance and to condone nothing less. — PETER F. DRUCKER, *in his book Landmarks of Tomorrow. New York: Harper and Brothers.*

SO YOU WON'T

is showing preference to your co-workers.

Be factual. Tell him that Wednesday not only did you have your own work, but, in addition, he gave you the job of supervising another unit which was out of your line, and *not* in your position description. This will demonstrate that you are not trying to "build an empire," or to get his job.

3. Carry your feelings "on your sleeve" and take exception to everything anyone says to you.

When you see a group of people talking, feel that they are talking about you. Don't let the opportunity pass to get even by talking about them. When you sit down with a group that is drinking coffee, and some of them immediately get up and leave, start thinking about how your feelings are hurt. Above all, don't dare let yourself think that they have merely finished their coffee and have to get back to work. All geniuses are temperamental and sensitive, so why should you be different?

4. At staff meetings, silence is golden. Don't go to the trouble of explaining what you know about the subject.

Keep them guessing. Keep your mouth shut. Never take notes, as most of the topics are not worth repeating to employes in your own unit. Be tardy for staff meetings. They will soon learn that they can get along without you, and it won't be necessary for you to attend.

5. Feel that the best methods for doing things have already been worked out, and never give thought as to how they may be improved.

When your supervisor asks you why you are doing something a certain way, give him your own standard answer, "That's the way it has always been done." After all, why bother trying to improve something that's already working?

6. Always use four syllable words when talking and writing so others won't understand.

Consult the dictionary frequently for words that have a number of meanings, so that no one can pin you down. By the time they have been able to interpret your meaning (if you had one!), the subject has been changed. Consider that the administrator's new 4-S (simplicity, shortness, strength, sincerity) program of letter writing should be ignored, and is of no consequence.

7. Never discuss your problems with anyone else, or ask assistance in solving them.

Forget the old adage that two heads are better than one — two heads would double the confusion.

8. Spend all of the funds allotted to your unit, whether or not you need the items.

What's the difference? It's only hospital money, and if you don't spend it, they may cut your department budget.

9. Leave home a few minutes later in the morning so you can come in a short time after 8 a.m.

Always quit at 4:20 p.m., so you can be ready to go home at 4:30 p.m. Feel that this is your privilege, and that you are familiar with the fact that employes may be excused for a few moments.

There are countless ways to ensure failure. Learn them and avoid them. Keep yourself mentally alert to these pitfalls. *Think* — would this be the path to failure? If so, take another route — and perhaps by doing so, avoid failure. ■

Survey indicates

Hospitals Do Little To Level Occupancy Rates

While 77 per cent of the hospitals surveyed reported seasonal fluctuations in occupancy, only about a third of the administrators were doing anything to overcome them

FEW hospitals apparently are doing all they can to achieve a high constant level of occupancy throughout the year.

A recent survey dealing with factors that affect hospital occupancy rates* disclosed that seasonal highs and lows in admissions took place in approximately 77 per cent of the reporting hospitals. Only two-thirds of the administrators of these hospitals, however, are concerned with seasonal highs and lows, the findings indicated.

Vacations Are Chief Cause

Vacations seem to be the chief culprit; two-thirds of the respondents attributed these seasonal fluctuations to patient or physician vacations, or both. Holidays were given as a reason by 46 per cent.

When questioned about what they were doing to maintain an even level of occupancy, only 35 per cent of the administrators reported taking any steps to overcome this problem.

Of the 26 steps reported being taken (see panel at right), 16 were aimed directly at the problem of leveling the occupancy rate. The other 10 steps taken were measures to adjust the operations of the hospital to conform to the existing occupancy level.

*This material is based on studies conducted by Armbruster, Moore & MacKerell, Inc., Hospital Purchase Audit Service, Glenside, Pa.

Administrators Offer Some Methods

What Administrators Have Been Doing

- *Improved nursing service
- *Employed a full-time pathologist
- *Employed a full-time radiologist
- Instituted Saturday and afternoon O.R. hours
- Instituted medical staff educational program
- Scheduled vacations
- *Offered beds for convalescent care at reduced rates during summer
- Scheduled maintenance in low occupancy periods
- *Less stringent admission criteria
- *Public relations
- *Discussed with staff spreading out of elective surgery
- *Encourage avoidance of peak periods
- *Air-conditioned patient areas
- Increased shortage of beds levels peaks and valleys
- *Have provided facilities for all phases of care
- *Added a nursing home annex
- Grant leaves of absence
- Holding vacated positions open
- Close one or two nursing units during low periods
- *Adding surgeon
- *Encouraged new doctors to join staff
- *Encourage doctor participation in hospital functions
- Discussion of the problem
- *Added more resident practitioners
- Converted communicable disease units into private rooms
- *Keep an elective and an urgent waiting list

*Indicates steps aimed directly at the problem. Others are measures to adjust the operation of the hospital to conform to the existing occupancy level.

None of the steps listed was taken by more than five administrators.

The ideal occupancy level for each month of the year, averaged from all survey replies, hovered around 80 per cent.

Analysis of the replies suggests that administrators would like to lower the occupancy rates in January, February and March and raise the occupancy level during the last six months of the year. Occupancy levels for April, May and June in 1959 were approximately the same as the average ideal level for those months.

Approximately two-thirds of the respondents said that they do not keep beds in reserve when there is a waiting list.

The reasons most often mentioned for not keeping beds in reserve were: no waiting list; can set up extra beds in halls and nursing classrooms; doctors' pressure won't permit it; first come, first served; bed shortage. Other reasons mentioned less frequently were: not necessary; no critical bed shortage; another hospital in town; community "overbedded" due to short patient stay; waiting list includes too many critical patients.

Almost all of the administrators (89 per cent) who reported that they did maintain empty beds even though there was a waiting list did so to accommodate emergencies or accident cases.

Other motives for maintaining a reserve were: to have rooms available for special use; for isolation cases; for intensive care units, and for obstetrics only.

Almost nine out of 10 hospitals admit patients who reside in an area served by another hospital, the survey pointed out. Physicians were the main reason for this.

Physicians Are Main Influence

The study found that in more than 70 per cent of the cases where patients came from an area served by another hospital, they were influenced in one way or another by physicians. Such influences included: referred by doctor, reputation of medical staff, and specialists available at hospital. Other reasons mentioned were: patients like hospital or hospital's reputation; special services offered by hospital; accidents and emergencies; lower costs; religious preference; to be near relatives or friends; better nursing service; admit indigent patients.

More than half of the administrators who answered the questionnaire said that they encourage the admittance of patients who do not reside in their hospital area.

Methods of encouragement were rather general, however, and were usually concerned with the general well-being of the patient and the continual improvement of the hospital's facilities and medical and technical staff. Some use of public relations to attract patients was reported.

Although a majority of administrators were trying to attract patients, many of them apparently overlooked the fact that other hospitals were doing the same thing. Less than half (48 per cent) of the respondents said they were doing anything to discourage patients from going to other hospitals.

Some of the methods reported by those who were trying to keep the patients in their own area are: adding, expanding or improving facilities; encouraging specialists and other doctors to join staff; public relations; educational programs, and improvement of patient care. ■

for Leveling the Occupancy Rate

What Administrators Think Might Be Done

Prevent physicians from taking summer vacations
Industrialization of community; diversify industry
Bargain rates during periods of low occupancy
Better supply of personnel
Air-condition hospitals or patient areas
Good selling job
Reduce rates for diagnostic services on week ends
Constant employment 12 months per year
Public relations
Have doctors not be subject to call at every hour of day
Better scheduling of elective surgery
Build new facilities
Longer patient stay
Clinics and medical centers stop performing hospital duties
Cooperation of medical staff
Time payment for care
Prepaid insurance
More public health work on respiratory diseases
Increased population of the community
Attract more physicians to community
Stable population in surrounding areas
Use waiting list to level occupancy
Encourage doctors to admit patients on week ends
Have fewer beds than the demand requires
High level quality of service
Strive for top-notch teaching program
Encourage staff vacation scheduling
Regional community planning
Take no vacations
More doctors in community
Control the weather

Seek New Ways To Improve Procedures, Speakers Urge Catholic Hospital Delegates

DETROIT. — Probably the best ventilated minds in the hospital field belong to the 5300 administrators and department heads who attended the Catholic Hospital Association convention here June 12 to 15. For four days the delegates were exhorted to innovate, activate, delegate — to try new ways of doing things, to release their death grip on their departments and let somebody else have a shot at running them.

If some of the Sisters (as corridor conversations indicated) thought it would be nice if at least one speaker would credit them with having had a new idea since 1900, they were far too polite to mention it publicly.

Theme of the convention was "Achievement Through Attitudes and Action," with special emphasis on methods improvement, and at least one Sister was quick to adapt the principle to improve her own method of getting around Detroit's foot-flattening convention hall. Spotting a staff messenger on an electric motorcycle, she gathered her robes around her, perched on the seat behind the messenger, and rode majestically off down the block-long corridor to the exhibit area.

The epigrams flew thick and fast at all meetings, particularly the general sessions at which the speakers obviously felt their talks would be most effective if they were entertaining as well as instructive.

Among the most successful epigrammatists was Dr. James E. McCormack, dean of Seton Hall College of Medicine and Dentistry, Jersey City, N.J., who spoke on the changing concepts of patient care.

Commenting on certain "eager beavers and promoters" on hospital medical staffs, Dr. McCormack seized the opportunity to register a complaint he has been harboring against hospitals. He expressed himself as being frequently amazed that "in so many hospitals under good auspices — church hospitals included — it has been possible for one person on the professional staff to become inordinately dominant. Too often, I am afraid, this is the most successful doctor on the staff. Financial success is not necessarily the best criterion of who the best doctor is. . . . You must not measure a doctor's value by the length of his Cadillac."

Another situation deplored by the speaker for which he believes hospital administrators are equally responsible with physicians is that too many physicians today fail to realize that the governing board of the institution is responsible to the community for all aspects of the operation of the hospital, including medical care.

Following Dr. McCormack on the program, Sister Grace Marie, S.C., administrator of St. Mary-Corwin Hospital, Pueblo, Colo., demonstrated that at least one administrator is aware of the need for both creative and cooperative thinking in hospitals.

After outlining an impressive list of operational improvements that have been made in her hospital through the efforts of an administrative council, Sister Grace Marie pointed out that long-range planning must be "an artist's sketch of the future, subject to modifications" because . . . "things change, prices change, staffs change, population statistics change, even viruses change. And the result is always that the problems change."

We need new ideas, the speaker continued, and "this is the job of the imagination. For some reason we tend to think of imagination as the domain of artists, poets, impractical dreamers, and children. We even become embarrassed at the thought of using our imaginations. Yet, if we are to cope with change, we need new ideas. If we are going to create change, we need new ideas. And new ideas come only from our creative imagination, from working and planning together."

A manager, according to Prof. James J. Cribbin, Ph.D., of New York University, must be engaged in a continuous program of balanced self-development with a view to heightening his technical skills, his managerial skills, and his human relations skills.

"Whenever you hear anyone talking today about the improvement of ethics, you can be pretty sure that he means the ethics of other people, not himself," Professor Cribbin stated. "Many managers operate on the same principle. They are interested in changing others, not themselves; in improving the work of their subordinates, not their own; in motivating inferiors, not themselves; in controlling others, not themselves; in changing the operating habits of underlings, not their own. Such an approach has never been typical of the Church. Its position has always been to improve the individual and inevitably society will improve; improve your own work ideals, objectives, attitudes and methods and those of your subordinates will surely follow. This is at once the task of the manager and the secret of true methods improvement."

Improvement is necessary to survival, the speaker indicated. "Of the hundred largest corporations in existence at the turn of the century," Professor Cribbin pointed out, "approximately two-thirds are no longer with us. Few institutions in America have a divine right to existence. If the American people do not receive what they feel is a fair return on their investment, then history tells us that they will seek out or develop a substitute that will do so. To wait until sheer social pressures or necessity require us to alter our mode of behavior or ways of doing things, as has so often happened in the past, is hardly the part of prudence or wisdom." ■

C.H.A. ELECTS NEW OFFICERS

Msgr. Schindler

Rev. Fitzpatrick

Above, left: Very Rev. Msgr. Clement G. Schindler, Belleville, Ill., assumed the presidency of the Catholic Hospital Association for the coming year. Right: Rev. James H. Fitzpatrick, Jamaica, N.Y., is president-elect. Other association officers are: first vice president, Rev. John A. Trese, Detroit, and second vice president, Rev. Paul R. Moore, Chalmette, La.

The negative approach proved a positive asset to this sprightly program designed to teach nurses how not to treat patients

The Perils of the Patient Are Shown in Nursing Skit

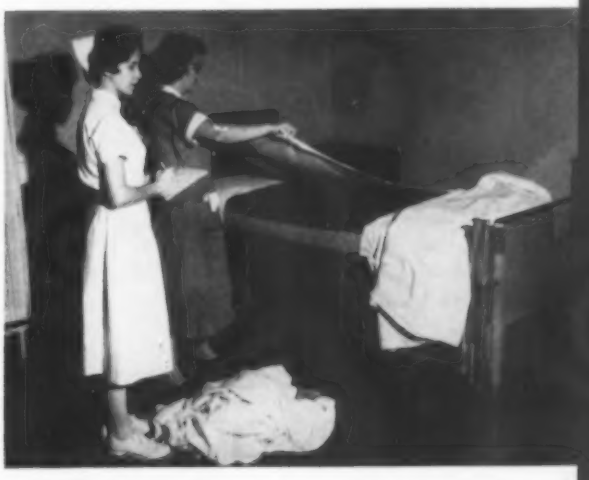
LEARN by laughing was the education theory behind a comedy of errors skit presented by nurses at MacNeal Memorial Hospital, Berwyn, Ill.

The perils of a patient were dramatized in a demonstration that "magnified the little mistakes that creep into the routine of nursing and patient care through carelessness," according to Mary Louise Evans, MacNeal nursing director, who suggested the idea.

The situations were planned by Margaret Schimming, R.N., an administrative assistant and clinical instructor. The 30 minute skit showed the patient as a victim of 30 different errors, from subtle mistakes recognized only by the professional nurses to situations even a pediatric patient could spot, she explained. An athletic orderly, an untidy bedmaker, a gruff emergency room nurse, flittering head nurse, and a blase aide are portrayed.

The live audio-visual aid was presented as part of the hospital's inservice education program. ■

"Orderly" shows that a shove is one way — the wrong way — to move patient from stretcher. Below: "Bed maker" uses the floor, but the "head nurse" hasn't noticed — or has she?



ABOUT PEOPLE

Administrators

O. H. Guenther has been appointed director of the Milwaukee County Institutions and Departments, Milwaukee, succeeding **John W. Rankin,** whose resignation was announced in the December issue of The MODERN HOSPITAL. Mr. Guenther joined the Institutions' staff in 1942 and has been deputy director for the last seven years. He is a trustee of the Wisconsin Hospital Association.


O. H. Guenther

Robert S. Hoyt has accepted the directorship of Perth Amboy General Hospital, Perth Amboy, N.J. He succeeds **Anthony W. Eckert,** who has become chairman of the board of governors and will devote full time to Perth Amboy's expansion program. Mr. Eckert is a past president of the A.C.H.A. Mr. Hoyt was administrator of Lutheran Hospital, Baltimore. He is the president of the Lutheran Hospital Association of America and a past president of the Maryland-District of Columbia-Delaware Hospital Association. It was also announced that **Lt. Col. Thomas Pugh, M.S.C.,** has become assistant administrator of Perth Amboy. Colonel Pugh had been executive officer of Patterson Army Hospital, Fort Monmouth, N.J.

Dr. Ernest N. Boettcher has been named executive director of Hartford Hospital, Hartford, Conn., succeeding **Dr. Ernest C. Shortliffe,** whose resignation was announced in the May issue of The MODERN HOSPITAL. Dr. Boettcher received his medical training at the University of Alberta and his degree in hospital administration from the University of Toronto. He has been medical superintendent of St. Joseph's Hospital, Victoria, B.C., since 1956.

Edmund G. Lawler was recently appointed superintendent of Oak Forest Hospital, Oak Forest, Ill. He succeeds **Carl K. Schmidt,** who resigned. Mr. Lawler is a graduate of Loyola University and has a master's degree in hospital administration from Northwestern University.

George S. Buis has taken over the duties of director at Salem Hospital, Salem, Mass. He was formerly the director of the program of hospital administration at Yale University. From 1946 to 1950 Mr. Buis was associate director of the American College of Hospital Administrators. **George S. Watts,** who has been acting director at Salem Hospital, will continue as assistant director.

Robert E. Trimble has accepted the position of administrator of Hialeah Hospital, Hialeah, Fla. He was previously administrator of Ardmore Sanitarium Hospital, Ardmore, Okla., and assistant administrator of Florida Sanitarium and Hospital, Orlando. Mr. Trimble is a past president of the Oklahoma Hospital Association.

J. O. Bush is the new administrator of Reagan Memorial Hospital, Big Lake, Tex. He succeeds **Carl Jackson,** who is now business manager at All Saints Episcopal Hospital, Fort Worth, Tex.

Charles D. Jenkins has resigned as administrator of Whitesburg Memorial Hospital, Whitesburg, Ky., to become administrator of Montgomery General Hospital, Olney, Md. Mr. Jenkins received his master's degree in hospital administration from the Medical College of Virginia. He succeeds **M. B. Tuttle,** who resigned.

George A. Van Gemert became administrator of Rahway Hospital, Rahway, N.J., July 1. He succeeded **Ivy Livingood,** who retired after 29 years as administrator of the hospital. Mr. Van Gemert has been assistant administrator of Rahway for the last four years.

Ronald Kohr recently became administrator of the Wm. S. Major Hospital, Shelbyville, Ind.

Garrett Graham is the new administrator of Jay County Hospital, Portland, Ind.

Marilyn D. Dodd, R.N., has been appointed administrator of Valley Doctors Hospital, North Hollywood, Calif. She had been assistant director. **Catherine Hoyt** is the new assistant director.

James D. Harvey has been named administrator of Hillcrest Medical Center, Tulsa, Okla. He succeeds **Bryce Twitty,** whose death was announced in the June issue of The MODERN HOSPITAL. Mr. Harvey has been assistant administrator of Hillcrest since 1955. He is a fellow of the American College of Hospital Administrators, president of the Tulsa Hospital Council, and treasurer of the Oklahoma Hospital Association.


James D. Harvey

Dale O'Donnell has become administrator of Curry General Hospital, Gold Beach, Ore. He succeeds **Nina Stansell,** who resigned.

Eugene F. Gibson Jr. has resigned as administrator of Baldwin County Hospital, Milledgeville, Ga., to become administrator of the new Coweta General Hospital, Newnan, Ga. **J. W. Singleton,** administrator of Meriwether Memorial Hospital, Warm Springs, Ga., will succeed Mr. Gibson at Baldwin. **Jack L. Moore** has succeeded Mr. Singleton at Meriwether.

Herbert Fromm, former assistant administrator at Ball Memorial Hospital, Muncie, Ind., has been named administrator of Logansport Memorial Hospital, Logansport, Ind. He succeeds **Howard R. Jones,** whose new appointment was announced in the last issue of The MODERN HOSPITAL.

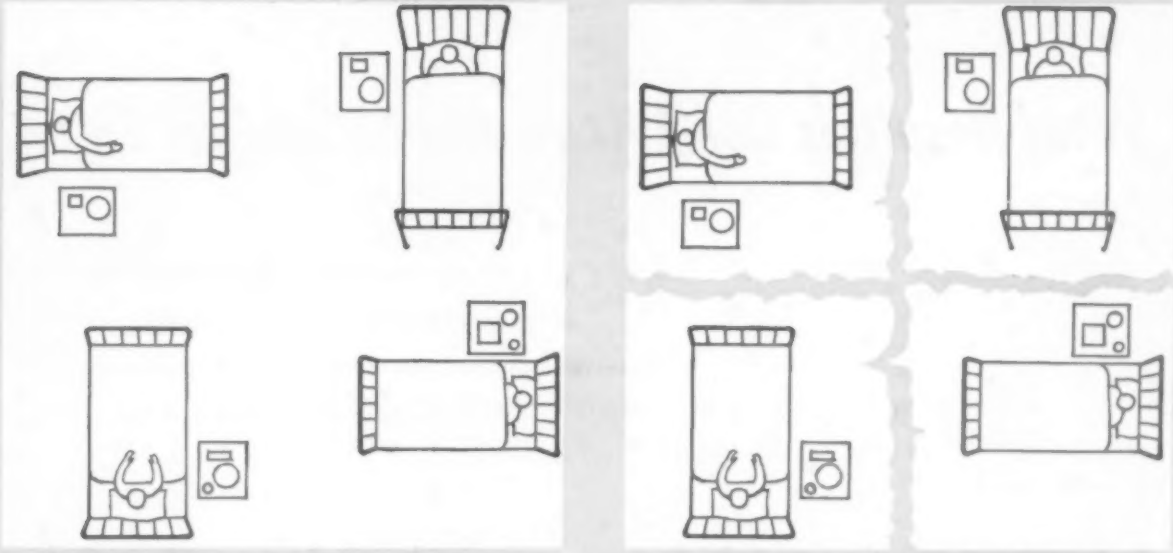
Dr. Oscar K. Diamond has been appointed director of Manhattan State Hospital, New York. He had been assistant director at Creedmore State Hospital, Queen's Village, N.Y.

Thomas J. Coy has been named administrator of Rideout Memorial Hospital, Marysville, Calif., succeeding **Fred W. Moore.** Mr. Coy has been assistant administrator at Rideout since 1954.

Kermon A. Pedersen has been named administrator of Riverside Hospital, Toledo, Ohio. Mr. Pedersen has been assistant administrator since August 1959 and acting administrator since January 1961.

(*Continued on Page* 152)

isolation WITHOUT separation



It can be done with the Lehn & Fink Tergisyl/Amphyl Spray team

Regular and frequent use of these two bacteriologically documented Lehn & Fink disinfectants as a team works to build a chemical barrier to cross infection and creates a continuously more aseptic environment without physical barriers.

Use Tergisyl Detergent-Disinfectant for dependable microbicidal cleaning of all floors, walls, and furniture.

Use Amphyl Spray to disinfect irregular surfaces, hard-to-reach areas, and objects or areas subject to frequent recontamination by patients or personnel.

Tergisyl Detergent-Disinfectant

is specially formulated by Lehn & Fink to disinfect as it cleans, or clean as it disinfects. Whichever way it is described, Tergisyl has many advantages in achieving chemical isolation. In the recommended 1:100 use dilution, this highly refined synthetic phenolic is dependably *staphylocidal, pseudomonacidal, fungicidal* and *tuberculocidal*—making it highly suitable for areas of high infection hazard, such as the operating suite, as well as patient areas with contagion potential. Combining efficient detergency with disinfection effects substantial savings in labor costs. On-the-job tests in a 100-bed hospital show a *reduction in labor* costs ranging from *22% to 47%* depending upon equipment used. No rinsing is needed. Conductivity of floors is unaffected. Complete literature on procedures is available on request. Available in 55, 15, and 5 gallon drums.

Amphyl SPRAY Disinfectant-Deodorant

is specially formulated and packaged for easy application to almost any area easily contaminated by human contact or, because of its shape or location, difficult to reach with liquid disinfectants. To help achieve chemical isolation of every patient from cross infection, use Amphyl Spray on light switches, door handles, toilet seats, telephones, bedsprings, bedside tables, radiators, air ducts, etc. *Staphylocidal, bactericidal, fungicidal* and *tuberculocidal*—Amphyl Spray has the same wide microbicidal spectrum as Tergisyl and supplements general disinfection and cleaning. It is an efficient deodorant and a mildewcide, too. When you take a look at the label, you'll want a supply for every service and nursing station in the hospital. Colorful 16-oz. cans are available in cases of 24.

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Conducted by Grover C. Bowles Jr.

What Hospitals Don't Know About Surgical Suites

Here are some problems of design and function of the surgical suite that need answering. Unbiased research into these and other phases of hospital operation is clearly indicated, this architect contends

Warwick Smith

AN EXCESS of opinions and an almost complete absence of reliable research hamper the field of hospital architecture. Yet, it seems to me, few architects realize the absence of basic design criteria.

The lack of investigations into many of the problems of the surgical suite and the difficulty of obtaining significant and reliable information have been obscured by the publication from time to time of some unsubstantiated information and quasi-research. The type of quasi-research of which I am most suspicious might be termed "the statistical approach." This method of investigating a problem is to send a questionnaire to a number of hospitals, calculate the average of the answers received, and then publish the result with the implication that it is the solution to the problem.

This kind of research is usually published in the form, "hospitals of x beds require y operating rooms," or "the surgical suite should occupy z per cent of the total floor area of the hospital."

No mention is ever made of such variables as the type and size of the surgical caseload, the percentage utilization of each operating room, and so forth (for it often happens that the questionnaire did not attempt to obtain these facts), and, consequently, the published results are not only useless as research, but may also be misleading.

More research on the design and function of the surgical suite is clearly needed. It must, however, be carried out by qualified, critical and unbiased investigators. Here are some of the subjects that might be investigated first, because they appear to be most likely to influence the future development and design of the surgical suite.

Causes of Infection

The most far-reaching and urgent problem needing a solution is the discovery of the sources of infections acquired by patients and personnel in the surgical suite, and the extent of the infections.

Up to 1950 there were few references in hospital literature to infections acquired in hospitals, and the subject was discussed only *in camera*. At present, hospital-acquired infection has attained such respectability that articles occur regularly not only in medical journals but in popular magazines and daily newspapers. The administrator who once denied that cross-infection occurred now readily admits that it happens, although in his particular hospital it is below the "national average." What the "national average" is cannot be discovered, but it is comforting to know that all hospitals are below it!

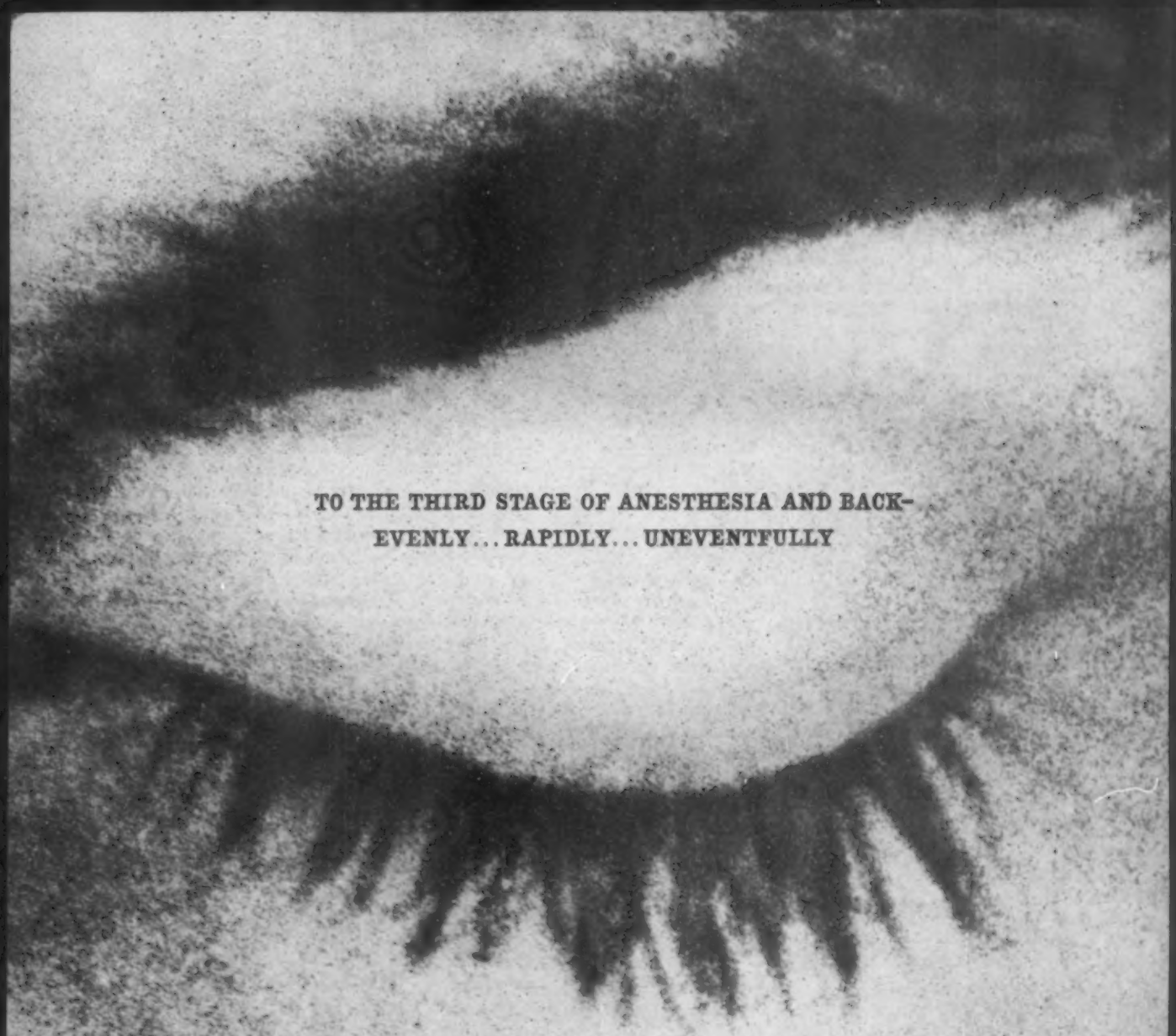
There has been no research carried out to establish a relationship between the plan of the surgical suite and the cross-infection rate, *e.g.* it is not known whether the generally accepted operating room-substerilizing room-operating room plan, where two operating rooms share one substerilizing room, has a higher or lower cross-infection rate than a ring plan, where four or more operating rooms share a common substerilizing room.

Not all cross-infection is caused by or can be eliminated by designing the surgical suite in a suitable manner. The problem of the surgical glove which breaks and allows the infected "glove juice" to enter the wound cannot be solved by changing the architectural design or modifying the organization of the suite. Only greater knowledge of the sources of infection will indicate the part that can be played by the design of the suite in reducing cross-infection.

Some of the following technics, organizational methods, and types of planning have been accused of being the cause of cross-infection:

1. Bringing beds into operating rooms, with or without bedclothes, for transferring the patient to and from the operating table.
2. Bringing into an operating room any equipment (plaster cart, mobile x-ray machine) which is used outside the surgical suite.
3. Removing the operating table from the operating room.
4. Contamination of the wound by particulate matter, *e.g.* glove powder,

Mr. Smith, A.R.I.B.A., is an architect, Rockdale, Australia. A portion of this article was adapted from the appendix to his book "Planning the Surgical Suite."



TO THE THIRD STAGE OF ANESTHESIA AND BACK—
EVENLY... RAPIDLY... UNEVENTFULLY

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ULTRASHORT-ACTING INTRAVENOUS ANESTHETIC From smooth induction to prompt recovery, SURITAL sodium (thiamylal sodium, Parke-Davis) provides specific advantages both for surgical team and patient. Adaptable to most operative and manipulative procedures, it assures a uniformly sustained plane of anesthesia, plus low incidence of laryngospasm and bronchospasm with minimal respiratory depression. And because SURITAL sodium rarely produces nausea or vomiting, it contributes significantly to greater patient comfort. See medical brochure for details of administration and dosage.

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What is the correlation between the number and type of operations and the number of operating rooms?

plaster dust, lint, droplets and droplet nuclei.

5. Failure of personnel, including visitors, pathologists, engineering maintenance staff, and so forth, to change completely into scrub clothing before entering the "restricted" area of the suite; to change shoes or overshoes between operations; to change masks frequently; to use a suction point under the operating mask; to use a skin cream on exposed facial skin.

6. Use of a back table or a multiple table setup.

7. Bringing outpatients into the suite.

8. Removing and renewing plaster casts in the suite.

9. Failure to prevent personnel working in the suite who are persistent and dangerous carriers, who have colds, skin lesions, and so on; failure to culture floors, wheels of equipment, anesthesia equipment at regular intervals.

10. Failure of orderlies who move between the suite and other areas of the hospital to change completely when reentering the suite on each occasion.

11. Use of disinfection (bactericidal liquids, formalin "sterilizers," and so forth) for instruments and supplies which should be sterilized.

12. Surgical suites designed in such a way that through traffic occurs and a "restricted" area cannot be achieved; general traffic passes the doors of operating rooms; "clean" preoperative traffic crosses or mingles with "dirty" postoperative traffic; contaminated instruments and utensils have to be transported considerable distances to a cleanup area for terminal sterilization, thus spreading contamination; "clean" and "dirty" processes have to be carried out in the same room.

Patient Traffic

1. How often do patients suffer injury during their stay in hospital: (a) during transport on stretchers to the surgical suite, (b) falling from beds or stretchers when waiting preoperatively in the suite without supervision, and (c) wound disruption caused by lifting or carrying patients when transferring them postoperatively from the operating table?

2. What are the respective medical and psychological advantages of beds, postanesthesia stretchers, and ordinary stretchers as patient conveyances?

3. For what length of time do patients wait preoperatively in the suite due to premature arrival or late arrival of a member of the surgical team?

4. What is the best method of accommodating the patient waiting preoperatively within the suite: (a) to ensure adequate supervision, (b) to prevent patient "mixup," (c) to avoid destruction of the effects of premedication?

5. At what point does it become economical to operate for longer than a single nursing shift? What are the physical and psychological implications for patients undergoing surgery in the evening and at night?

Personnel Traffic

1. What are the advantages, if any, of using hot air hand dryers instead of sterile towels after scrubbing?

2. What are the advantages, if any, of using waterproof aprons when scrubbing?

3. Is there any relationship between hand contamination after scrubbing and the distance from the scrub-up sink to the operating room?

4. What is the possibility of hand contamination being caused by nail cleaners (*e.g.* orange sticks) which cannot be sterilized?

5. What is the best method of protecting the surgical team during diagnostic x-ray procedures and the implanting of radioactive substances?

6. Are the advantages of conductive overshoes (*e.g.* ease in providing a clean pair to each member of the surgical team for each operation) offset by their clumsiness, which might lead to falls and consequently injury to personnel?

The Size of the Suite

1. What is the surgical caseload to be expected from a given community? How is a community survey to obtain this information?

2. What is the correlation between the surgical caseload (*i.e.* the number and type of surgical operations) and the number of operating rooms? To what extent is this influenced by: (a) length of each day's operating schedule, (b) range of surgical specialties, (c) the type of work performed (*e.g.* emergency, urological, outpatient procedures may not be performed in the suite), and (d) teaching facilities?

3. What percentage utilization is it reasonable to expect from an operating room? (In existing hospitals, what percentage of time is devoted to preoperative preparation, surgery, postoperative cleanup, and nonutilization?)

4. Is there any relationship between operating rooms and the total bed count of a hospital? (Is it logical for public health departments to establish a maximum beds-to-operating rooms ratio?)

Clean and Sterile Supplies

1. Is it desirable to process some supplies used in the operating room in a nurses workroom in the suite to utilize unoccupied time of nurses in the suite?

2. What is the extent of storage facilities needed for surgical instruments, and the merits of different methods of storing instruments in relation to ease of preoperative instrument selection? What are the merits of storing instruments in wrappers in a sterile condition?

3. How effective are washer-sterilizers in sterilizing surgical gloves and suction tubing, especially in relation to the dirty case technic?

4. To what extent do washer-sterilizers cause instrument damage, (especially to sharp edges by corrosion and agitation) and protein build-up on instruments?

5. What is the rate of infection among personnel who handle postoperatively instruments that are not terminally sterilized? How effective is it to soak used instruments in a germicidal solution before they are washed by hand? (*Cont. on Page* 96)

How can the surgical caseload be related to the number of beds required in the recovery room?

(*Continued From Page* 94)

6. What are the economies of dry heat, pressure steam, and ethylene oxide sterilization of sharp instruments in relation to damage caused and time taken? How effective is ethylene oxide on soiled instruments?

7. Is it economical to dry washed instruments in drying cabinets to prevent corrosion?

8. What is the extent of soil (*e.g.* detergent residues, corrosion products, salt and grease from fingers) on "clean" instruments, and should it be removed before instruments are sterilized preoperatively? What is the effect of this soil on the surgical wound?

9. Is it economical to sort linen from the surgical suite to look for lost instruments (*i.e.* labor cost *versus* cost of lost instruments and damage to linen during washing)? Is there danger of cross-infection due to aerial contamination caused by linen being sorted in the suite?

10. Is it necessary to use a high-vacuum sterilizer for sterilizing a bag of instruments after a dirty case to ensure air removal from basins inside the bag, as the basins cannot be placed to ensure air spill?

11. Is paper as effective as cotton for wrapping sterile objects? (Paper has no filtering action on air drawn into packages which are compressed and then expand.)

12. How should sterile kits be stored? What is the danger of contamination to kits stored on open shelving by splash from floor washing and by dust?

13. Is it desirable or essential to use sterile waterproof sheeting on top of instrument tables to prevent contamination of sterile cotton or paper wrappers, which would occur if the tables were wet?

14. How much aerial contamination is caused by "shaking out" sponges to ensure the correctness of the sponge count?

15. Is it economical or dangerous to save and reuse sponges?

Operating Rooms

1. What are the relative merits of galleries, domes and closed-circuit color television for observation for undergraduate and postgraduate teaching?

2. What are the relative merits of different types of surgical lighting, including the egg-shaped operating room with ceiling light sources?

3. What items of fixed equipment are needed in an operating room, and what is the most suitable location for each item?

4. To what extent are film illuminators utilized, and what number is required?

5. Are doors needed on storage cabinets to prevent contamination of supplies by glove dust, lint, splash from cleanup, and so forth?

6. It is desirable to provide floor drains in operating rooms? Is there any evidence for drains drying out or spreading infection?

7. What is the level of aerial contamination caused by the use of plaster from a plaster cart in an operating room, and how dangerous is it?

8. Are there any statistics relating to explosions in air conditioned cystoscopy rooms which indicate that the rooms should be designed as hazardous locations?

Department of Anesthesia

1. What are the psychological and medical advantages and disadvantages of induction rooms?

2. Has an explosion ever occurred in either an air conditioned or non-air conditioned suite with conductive floors when a patient was being moved from an induction room to an operating room while an explosive anesthetic was being administered?

3. What is the frequency of cases which are "difficult" to induce and which cannot be predicted?

4. Are there any recorded explosions in storage rooms for combustible gases in surgical suites?

5. Is it necessary to provide in storage rooms for combustible gases (a) sparkproof flooring, (b) cylinder racks of nonferrous materials, (c) ground connections to metal cylinder racks?

6. Should cylinder racks in storage rooms for oxidizing gases be made of incombustible materials?

7. What quantities of all medical gases are used in surgical suites of different sizes?

8. Is it necessary to limit the storage of gas in cylinders in the surgical suite to a "48 hour supply"? What is a "48 hour supply" of oxygen in cylinders for a suite with piped oxygen?

The Ancillary Rooms

1. How can the surgical caseload be related to the number of beds required in a postanesthesia recovery room?

2. How many scrub positions are needed for operating rooms serving different types of caseload? What is the utilization of scrub positions in existing hospitals?

3. To what distance is splash scattered during scrubbing? Is it related to the type of scrub fixtures and faucets and their mounting heights? Can infections be spread from one person scrubbing to the person at the adjoining scrub position?

4. To what extent are dictating cubicles used in surgical suites? How many cubicles are needed in suites of different sizes?

5. What is the utilization of sterilizers in substerilizing rooms of orthodox design in existing hospitals?

6. Are warming cabinets needed in the surgical suite for (a) external liquids in the operating rooms, (b) for blankets in the recovery room?

Heating and Ventilation

1. What standards should be adopted for investigating air quality, *e.g.* what is the most efficient bacteriological sampler? Should bacteria be in the dry state when released into the air stream?

2. How much of previous aerobiological research, carried out in suites which had only natural or mechanical ventilation, is applicable to air conditioned surgical suites?

3. What temperature, relative humidity, and air movement is best suited to exposed tissue, irrespective of other considerations?

(*Continued on Page* 98)

NEW A.C.M.I. STERILE DISPOSABLE URETERAL CATHETERS

For the patient: Freedom from catheter-borne infection.
For the hospital: Freedom from catheter-handling drudgery.

A.C.M.I. Sterile Packaged Ureteral Catheters, designed to be used once and then discarded, protect the patient from catheter-borne infection, and relieve nurses and hospital personnel of time-consuming washing, rinsing, sterilizing and maintenance of catheters in sterile storage. Other advantages:

- Ready for instant use
- Smooth, highly polished surface
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Supplied in half-gross cartons.

Sealed sleeve easily opened by peeling back tabs, without touching catheter.

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Catalogue Nos.
2001 SP — Whistle Tip
2003 SP — Olive Tip
2005 SP — Round Tip
Sizes: 4 to 10 Fr.

(*Continued From Page 96*)

4. Is there a relationship between bacterial count (in colonies per cubic foot) and postoperative cross-infection rates?

5. Has urban "smog" any affect on exposed tissue?

6. What is the danger of air contamination if air intakes are located (a) in area ways, (b) at ground level, (c) near parking lots, (d) near exhausts from bacteriological laboratories, vivaria, incinerators and so forth?

7. What are the relative efficiencies of air filters (a) when clean and when dirty, (b) related to particle size, (c) in removing bacteria and viruses?

8. To what extent do air washers, dehumidifier coils, and dirty filters contaminate the air stream?

9. How efficient is activated charcoal as a filter and as a bactericide?

10. What is the experience in existing air conditioned surgical suites using recirculation of air in relation to (a) cross-infection rates (How do they compare with 100 per cent fresh air?), (b) evidence of explosion caused by passing recirculated air through electrostatic precipitators, (c) evidence of explosions in rooms with conductive flooring?

Materials and Finishes

1. Should acoustic tiles be used in operating rooms? What are the characteristics of tiles available at present with special reference to washability, air percolation from above, and attraction of dust by static charge?

2. What are the characteristics of conductive flooring materials available at present, with special reference to resistance to indentation, scratching, electrical resistance when dry and wet, resistance to commonly used chemicals (*e.g.* hexachlorophene)?

Engineering Services

1. What are the relative costs for small and large suites of (a) piped medical gases versus individual cylinder supply, (b) piped suction versus individual portable suction machines?

2. What standards should be adopted for piped compressed air for medical purposes? To what extent does the compressing of air have a bactericidal effect?

3. What are the relative costs for small and large hospitals of central vacuum cleaning versus portable vacuum cleaners? What degree of aerial contamination is caused by different types of portable vacuum cleaners when clean and when dirty?

4. How often have breakages in gas pipelines occurred? How often have shut-off valves been accidentally or deliberately closed by unauthorized persons? Have either of the above breakdowns to the service caused injury to patients or damage to the building?

It may seem strange that so many of the subjects for research listed here are not architectural, but concern medical standards and practice. However as soon as consideration is given to the design of the suite it becomes obvious that all these matters are relevant, and some of them profoundly affect the design. Until the answers have been provided to these problems, the design of the suite must continue to be based on assumptions, some of which appear to be increasingly doubtful in the light of present knowledge of cross-infection. Only facts can provide a sound basis for the design of the surgical suite. ■

arresting measure for surgical bleeding

When the customary surgical techniques for capillary hemostasis fail, prompt cessation of oozing may usually be obtained with OXYCEL (oxidized cellulose, Parke-Davis). This absorbable hemostatic conforms readily to all wound areas...assures a clear operating field...helps to shorten operative procedures.

Available in forms for every need: OXYCEL (oxidized cellulose, Parke-Davis), Pledgets (Cotton-type), 2¼ in. x 1 in. x 1 in.; Pads (Gauze-type) (8-ply), 3 in. x 3 in. and 4 in. x 12 in.; Strips (Gauze-type) (4-ply), 5 in. x ½ in., 18 in. x 2 in., 36 in. x ½ in., and 3 yd. x 2 in.; Foley cones (Gauze-type) (4-ply), 5 in. and 7 in. diameters. Sterile as supplied.

Indications: As an adjunct to effect hemostasis in bleeding associated with capillary oozing. ***Use:*** Strips—temporary packing of bleeding cavities, nasal passages, and tooth sockets; pads—temporary packing of surgical beds as after biopsies and to cover more or less extensive areas as in laparotomies; pledgets—in neurosurgery and in dental work for small localized bleeding areas; Foley cones—in prostatectomy.

Precaution: Excess amounts should be removed prior to surgical closure to avoid foreign-body reaction. Not to be used in sites of infection or following silver nitrate or other escharotic chemical agents. Contraindicated in clean bone surgery when poor vascularization is present and in instances where rapid callus formation is desired. Should be used sparingly in open reduction of fractures and in cancellous bone. Will not withstand heat sterilization. Remove from container aseptically.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

absorbable hemostatic

OXYCEL

Most Pharmacists Don't Want To Do Bulk Compounding, Audit Shows

Grover Bowles Jr.

PRELIMINARY reports of the audit of pharmaceutical service in hospitals indicate that much factual information about hospital pharmacy practice in the United States will be available for the first time.

Grover Bowles Jr.

Although hospital pharmacy in this country dates back to the founding of the Pennsylvania Hospital in 1752, progress prior to 1920 was characterized by obscurity. Despite the dynamic progress that has been made in this specialty since the founding of the American Society of Hospital Pharmacists in 1942, the audit is the first meaningful study to be done in hospital pharmacy on a nationwide basis.

How the Audit Was Set Up

Initiated in March 1956, the audit was carried out by the division of hospital pharmacy of the American Pharmaceutical Association and the American Society of Hospital Pharmacists on a grant from the Public Health Service. Don E. Francke, director of pharmacy service, University of Michigan Hospital, was the principal investigator and was assisted by Clifton J. Latiolais. Gloria Francke and Norman Ho served as research associates.

The basic objective of the audit was to obtain essential data on the organization, personnel, facilities and services of hospital pharmacy which could serve as a guide to improve the quality of pharmaceutical service and, in turn, contribute to better patient care.

The survey research center of the University of Michigan provided assistance in planning and methodology, with particular emphasis on questionnaire construction and pretesting, scientific sampling procedures, and the coding and mechanical tabulation of data. Thus, the findings of the audit, pleasant or unpleasant, can be supported with documentary evidence.

The final report, together with recommendations, will be published later this year. Meanwhile, here are some reported findings:

Manpower studies indicate that in 1957 there were 4845 full-time and 988 part-time pharmacists in hospitals throughout this country. Using the 9.8 replacement factor, it was estimated that more than 1000 hospital pharmacists annually will be needed by 1975 to fill the needs of the country's hospitals.

Hospital pharmacy has a high percentage of young people.

One in three hospital pharmacists is less than 30 years of age and has been in hospital pharmacy practice for less than three years. More than half of all pharmacists practicing in hospitals are under 40 years of age. The ratio of men to women pharmacists in hospitals is 2 to 1, compared with a 9 to 1 ratio found in community practice of pharmacy.

As a group, hospital pharmacists feel they have a high degree of freedom to operate the department as they feel it should be operated. Given the choice of five answers ranging from very much freedom to no freedom at all, 91 per cent replied that they have much to quite a bit of freedom. Only 2 per cent said they have little or no freedom.

Ninety-one per cent felt their administrators were "sympathetic" to "very sympathetic" toward their objectives regarding budget, personnel, equipment and space requirements. Only 8 per cent felt their administrators were indifferent or unsympathetic.

Ninety-two per cent of the chief pharmacists felt the pharmacy is very well to well respected by the administration, medical and allied staffs of the hospital. Only 2 per cent felt that the pharmacy is not too well respected or not respected at all.

Salaries for hospital pharmacists in 1957 were poor compared to the employed pharmacist in retail practice. This comes as no surprise to pharmacists practicing in hospitals and accounts for much of the turnover of pharmacists that plagues hospitals.

What the Audit Revealed

The audit findings indicate that nine out of 10 hospital pharmacists provide basic pharmaceutical service (compounding and dispensing) to inpatients and departmental units. However, many hospital pharmacists are not particularly anxious to provide a more comprehensive service. For example, nearly half of the chief pharmacists do not want to teach, to operate a bulk compounding program, or to supply reagents and other chemicals to the hospital laboratories. Three out of four do not want to prepare sterile products. One in four does not want to operate under the formulary service, and three out of 10 do not want to provide outpatient pharmacy service.

While failure to provide comprehensive pharmaceutical service can be attributed to the lack of hospital orientation or lack of facilities, space and staff, the fact that many pharmacists do not want to provide more than basic service reflects a major shortcoming and presents a real challenge to the pharmaceutical educators and the leaders in hospital pharmacy. ■

New Staff Meeting Requirements Are Reasonable — and Overdue

Robert S. Myers, M.D.

THE recent decision of the Joint Commission on Accreditation of Hospitals to relax its requirements for medical staff meetings was reasonable and statesmanlike; it was also long overdue.

Dr. Robert S. Myers

Actually, the Joint Commission should not bear the entire blame for excessive delay in fitting its requirements to meet the valid and established practices of the medical profession. The Commission was merely continuing the essentials established by the American College of Surgeons for the latter's program of hospital standardization.

For almost 35 years the College had required that general medical staff meetings be held in all hospitals at least once each month in order to accomplish a thorough review of the clinical work; and this was in addition to regular meetings held by the various clinical departments in the large departmentalized institutions. Moreover, the College required the active medical staff to attend at least 75 per cent of the monthly staff meetings as a condition of staff membership.

The theory behind these dogmatic requirements of the College was that the general monthly staff meeting, properly attended by the active medical staff, was the best method of conducting an evaluation of the quality of patient care.

To be sure, when the College put this requirement into effect in its program of hospital standardization, it marked a great advance in medical staff organization, for previous to that time every physician was his own judge and jury and was not responsible to his colleagues for his individual actions. Moreover, this requirement accomplished much good, for it opened to review the records of all physicians practicing in the hospital and encouraged the medical profession to discipline itself.

There were, however, two basic deficiencies in the College's insistence upon monthly meetings of the entire medical staff and upon a certain percentage of compulsory attendance of the active staff at these meetings.

In the first place, general staff meetings attended by all physicians of diverse specialties were, and still are, an ineffective and inefficient method of evaluating the care of patients. This is properly a function of each clinical department. The various committees of each department should audit the work of the members of the department and report the results to the chief of that department. The frequency with which the individual departments meet will depend upon the needs and desires of the department. This pattern of departmental meetings, in lieu of regular, general medical staff meetings, has been followed traditionally by medical school hospitals. It is an established fact that few, if any, medical school hospitals could have been approved or accredited if the requirement for regular meetings of the entire active staff had been strictly enforced by the College and by the Commission. What is good for the medical school hospitals should be equally good for the others.

As for the College's mandatory percentage of attendance by members of the active medical staff: This requirement was not only unrealistic, it also was presumptuous.

It should have been the responsibility of the medical staff of each hospital to determine this requirement, since maintenance of the quality of adequate patient care is the only basis upon which to accredit a hospital. Attendance at staff meetings has nothing to do with this.

Now all is different. The Joint Commission has dropped its previous requirements for a quarterly meeting of the entire active staff and for an active staff attendance of at least 50 per cent. The Commission leaves it to the medical staff of each hospital to determine how and when its members shall meet to evaluate the clinical practice of the profession.

Any one of the following three methods will satisfy this requirement of the Commission:

1. Monthly meetings of the active staff.

2. Monthly departmental meetings in the hospitals with organized departments.

3. Monthly meetings of the medical records and tissue committees where the quality of medical work is adequately appraised, action taken by the executive committee, and reports made to the active staff.

Apparently, some hospital administrators are concerned that the new staff meeting requirements of the Joint Commission are a weakening of the standards for accreditation. Nothing could be farther from the truth. The new requirements recognize the established fact that there is more than one way to accomplish an adequate evaluation of patient care and that the method used depends upon the individual hospital.

In our experience with the medical audit program of the American College of Surgeons, we found that the most effective appraisal of patient care was obtained by the medical audit committee, whether it was a committee of the entire staff in the very small hospital or whether it was a committee of each department of the staff in the larger hospital. Such an audit should be accomplished by small groups; it cannot be done adequately in the hurly-burly of the general staff or departmental meeting. ■

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Operating Room Forum

Program To Train Surgical Aides Would Help Personnel, Hospitals

By Frances Ginsberg, R.N.

BECAUSE hospitals are often behind industry in their personnel policies and technics for realizing the greatest potential of their employes, competent people are sometimes not permitted, encouraged or motivated to move into new responsibilities.

Frances Ginsberg

This, I am afraid, is an indictment of some hospitals' attitudes toward their working force. However, my chief concern here is the loss of excellent personnel in the operating rooms, delivery rooms, and central service departments in the face of critical needs.

If those responsible for these activities would evaluate more carefully their nursing service personnel, they would, I am sure, find aides, maids, orderlies and practical nurses who are not only capable of learning and doing more, but also many who would welcome the opportunity for advancement. In the light of the current shortage of nursing service personnel and the dire predictions for the future, it is almost imperative that these people be more effectively utilized.

This is not a new idea. Today there are surgical technical aides working in hospitals and providing vital service by supplementing the supply of professional nurses in specialized areas.

What is a surgical technical aide? According to a manual published by the American Hospital Association, "a surgical technical aide is a selected lay person who, through a well planned and well organized course of instruction, is prepared to function intelligently under the direct and continuous supervision of qualified professional nurses within hospital areas intimately concerned with the principles and practices of surgical asepsis, *i.e.* operating room, delivery room, emergency room, and central service department. . . ."

Such aides do not constitute a threat to nurses. In contrast to this impression, professional nurses with whom they are now working in hospitals consider them invaluable and the long awaited answer to their needs in lieu of an adequate supply of professional nurses.

Where the value of this program has been recognized, the nurses themselves are developing programs to teach additional surgical technical aides. Their programs are based on established principles for such training as outlined in the A.H.A.'s Instructor's Guide for Training Surgical Technical Aides.

Four factors are essential in developing such programs. One is the recognition that every hospital has a number of nonprofessional people with the qualifications to make good surgical technical aides. The second is the understanding by nurses that such people, properly trained, are no threat to them. The third factor is the acceptance of such people by the surgeons. And the fourth is the willingness of both surgeons and nurses to assume teaching roles. ■

(See Page 107 for O.R. Forum Questions and Answers)

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.

This is the second of a series of articles on surgical technical aides. The first article appeared in the June issue. The series will be continued in August and September.

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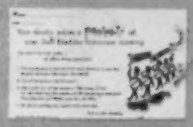

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O. R. Forum Questions and Answers

Many readers have asked questions about specific technics, procedures and other matters dealing with operating room nursing and aseptic practice. These questions have been forwarded to Miss Ginsberg and, since many of them were of general interest, she has agreed to answer them in this special section. Questions regarding operating room practice will be welcome and will be forwarded to Miss Ginsberg for reply in this column.

Sterilize Isolation Packages With Others

Is it necessary to run isolation packages as a separate load in an autoclave?

No, provided the period of sterilizing exposure is 30 minutes and the temperature is 250 F. A sterilizer that is properly loaded and not overcrowded will ensure the destruction of all forms of microbial life.

'Version' Gloves Can Be Kept Sterile

Since "version" gloves are seldom used in a delivery room, is there an effective way to maintain their sterility without reautoclaving?

Yes. There is an extremely effective way to maintain their sterility for an indefinite period. This can be done by fan-folding the sleeve of the gloves and putting gauze inserts within the folds. In addition, a sponge set in the hand portion of the glove, permitting steam to enter and air to exit, will assure sterility. For packaging, the routine for ordinary gloves, exposing them to not less than 20 minutes at 250 F., should be used. After being dried and cooled, the sterile package should be placed in a clean polyethylene bag and sealed.

How To Keep Hot Wet Packs Sterile

What is considered a satisfactory procedure for providing sterile equipment for hot wet packs on wounds?

Have the central sterile service provide a two-speed hot plate and a rubber sheet, or a supply of bedsavers with polyethylene backing. These should be kept in the patient's unit. For each treatment central service should dispense a wrapped sterile basin containing necessary gauze supplies and two hemostats, along with a small flask of the appropriate sterile solution (H_2O or saline). This equipment should be opened at the patient's bedside where the solution can be aseptically heated and used.

How To Sterilize Airways

We have no ethylene oxide sterilizer. How should we sterilize airways and endotracheal tubes?

Immediately after each use, place them in a detergent-germicide solution and soak. With gloved hands, using sponges, bottle brush and applicators, or both, clean thoroughly to remove organic debris. Then rinse in tap water. Autoclave airways if they are made of heat-stable materials. If not, soak with endotracheal tubes in a tuberculocidal solution for 20 minutes (70 per cent isopropyl alcohol, iodophors or selected synthetic phenolic compounds). Finally, rinse in tap water and store dry for future use. The chemical mentioned will disinfect only when used in sufficient concentration.

Conducted by Jane Hartman

How To Plan Menus That Please Patients

No matter how nutritious a meal may be, if the patient doesn't eat it, the menu planner has failed. Here are some general rules to help assure acceptability

Lt. C. E. Beyer; M. E. Ericson, and J. J. Wanderstock, Ph.D.

UNLESS the patient eats his meal, the menu is ineffective – regardless of how nutritious the meal may be, what its cost is, or how easily it may be prepared and served. Last month we discussed the menu from the standpoints of adequacy, cost and execution. Acceptability of the meal must be of equal importance to the persons responsible for planning the menu.

There are many factors that influence the degree of acceptability of a given meal, in addition to the manner in which the foods are prepared.* Some are inherent in the patient population and need to be considered by the menu planner; others are a product of the menu itself and can be more directly influenced by selection of menu items.

Climate and Weather

Meals with cold entrees and beverages, and slightly lower caloric content, are likely to be most acceptable during warm weather, while hearty, heavier meals are needed for the winter or in cold climates.

Food Habits

Food habits of patients vary by geographical location, race, religion and economical status, as well as by general environment. An attempt should be made to please the majority of the consumers as well as to change some of the set food habits of the minority groups, especially where these habits fail to supply an adequate and balanced diet. From this standpoint, the hospital can help its patients learn new and improved food habits and thus develop better standards of health and nutrition.

Occupation

The occupation of the patient should be considered in determining the type of food to which the patient is accustomed. The menu should be planned to provide the requirements for sedentary persons with the additional protein required for convalescent patients. It should also be remembered that the employes who take meals at the hospital will have different nutritional requirements than the average patient.

Age and Sex

If a hospital has a preponderance of one sex or age group, the menu planner should give special consideration to its food requirements, for example, lighter meals for a predominantly female population.

Variety

When the menu lacks sufficient variety, the patient must take what is offered and suffer in silence or make justified complaints. Neither situation improves patient morale. Since the advent of the selective menu, it is more difficult to control the foods selected by a patient; however, if a variety is offered, the role of the menu planner has been fulfilled and the actual selection is left to the patient.

Following are some of the factors that affect variety in the menu.

Repetition

Do not serve food prepared in the same manner day after day. Fried eggs and bacon are the basis for a popular breakfast, but not for breakfast on seven consecutive days. The menu planner should be constantly on the alert for different methods of food preparation.

Repetition may be the product of the work schedule of the employes. For example, a hospital where the bakers have every Sunday off might routinely serve ice cream for lunch and gelatin for dinner. This would not be apparent to someone eating on an occasional Sunday at the hospital, but to the long-term patient who observes the same thing every week, it becomes quite obvious and objectionable. It is easy for the person planning the menu to follow a pattern. There is also a tendency for the menu planner to list

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Lieutenant Beyer is in the medical service corps, U.S. Navy; Miss Ericson and Dr. Wanderstock are professors of hotel administration, Cornell University, Ithaca, N.Y. This paper was prepared while Lieutenant Beyer was a student enrolled in the school of hotel administration at Cornell, under sponsorship of the navy.

This article has been adapted by the authors from material appearing in the Food Service Manual of the United States Naval School of Hospital Administration, National Naval Medical Center, Bethesda, Md.

The opinions and assertions expressed in this article are those of the authors and are not to be construed as official or reflecting the views of the navy department or the naval service at large.

*Adapted from United States Army Student Workbook, Nutrition and Menu Planning, Fort Lee, Va., the Quartermaster School.

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foods of which he is particularly fond and to eliminate those foods for which he cares little. It is, therefore, important for the person planning the menu to be objective. It is a desirable practice to have someone other than the menu planner review and criticize the menu.

Color

It has been said that a person does 95 per cent of his eating with his eyes. Although this may be an exaggeration, appearance has a significant effect on the acceptability of food. By using foods that have a variety of colors, it is possible to give the patient's plate greater eye appeal. Foods should be selected which complement each other from the standpoint of color combination. The menu planner must therefore check each meal to ensure that there is sufficient color contrast to make an attractive presentation. Many times the addition of a slice of tomato, a leaf of lettuce, or a spiced apple as a garnish will give an otherwise dull appearing plate of food the necessary visual appeal.

Shape

The shapes of the various foods that make up the menu are less important than some of the other considerations; however, some effort should be made to vary the shapes of foods served. The addition of round, flat and other distinctive shapes can often enhance the appearance of the meal.

Consistency and Texture

These two factors are important to a well planned meal. An attempt to have one creamy, one crisp, and one crunchy food at a given meal will avoid monotony and improve the morale of those required to eat at the hospital.

Flavor

Avoid serving too many foods that have the same flavor at one meal. Tomato soup, spaghetti with meat balls, and a lettuce and tomato salad for lunch certainly would "overdo" tomatoes. Avoid a preponderance of strong flavored or distinctly flavored foods such as broccoli, cauliflower, cabbage or brussels sprouts. These should be served with some mildly flavored foods.

Use foods high in starch content with care. Another vegetable high in starch, such as corn or lima beans, may be used with potatoes, but aside from this combination, only one food high in starch content should be served at any one meal. Of course breads and cereals are considered separately and not in this category. Use should be made of varied sauces, flavorings and seasonings in order to enhance the flavor of the foods.

Preparation

As mentioned earlier, menu planing requires the use of different methods of preparation, both from an equipment standpoint and from the standpoint of the skills of the employes. Consideration should be given to the use of standardized recipes. With the use of such recipes, tested and standardized in the hospital kitchen, the food item should be consistent. Standardization of recipes can also be the basis for calculating food costs, thus eliminating a great percentage of food waste.

Tradition and Novelty

It is important to know the difference between tradition and routine.

(*Continued on Page* 112)

How To Write the Menu

THERE is no one best way for the menu planner to approach the problem of writing the menu. In many instances, much of the planning that goes into the menu takes place while the menu is actually being written. Regardless of the manner in which the menu is approached, the menu planner should follow the same procedure for all menus.

The following points tend to summarize the material covered in the accompanying article, as well as provide a step-by-step approach to preparing a menu:

1. The responsibility for initial planning of the menu should be vested in one person, usually the food service manager. It may be helpful for this person to meet with key personnel in the department to discuss the projected menu. By using this procedure, there can be an interchange of ideas, and, at the same time, employe interest may be stimulated. This will also provide a means for training key personnel in menu planning principles. Management must give its approval before the menu is put into effect.

2. The developing of the menu must be an orderly, systematic procedure. The person making it up should have the advantage of a quiet, comfortable place in which to work; one where concentration is possible, and where there is sufficient space to store previous menus, recipe books, files and the other necessary reference material.

3. Before starting to write the menu, the menu planner should have available information on items in the storerooms and refrigerators, as well as current information regarding the availability and cost of food items.

4. Plan the weekly menu item by item, not meal by meal.

— Select an entree for each of the 21 meals. Study these entrees to see if basic requirements are satisfied. If selection is offered, go back and list the other entree selections for each meal.

— Select the vegetables to accompany the entree or entrees.

— Select the soups, appetizers and salads which will best complement the entrees and vegetables.

— Finally, select the appropriate dessert to complete the meal.

5. Check the menu after completion and attempt to visualize each meal in terms of its appearance on the cafeteria line or tray going to the patient. It is a good idea to put the menu aside until the next day, and to check it again (see box on page 112). If it appears satisfactory, it can be typed. ■

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(*Continued From Page* 110)

There are certain national holidays or other special occasions when the patient expects a particular meal or meal component, and is generally disappointed if these items are not offered. There are also certain foods that just naturally seem to go with one another, like mashed potatoes and gravy.

Too often, the mere fact that chicken always is served on Sunday is considered tradition, when in fact it is merely repetition. However, care must be taken that innovations are not so unusual as to limit acceptance or result in meals that are inappropriate.

How To Check for Acceptability

THE following points should be considered before putting the menu into production:

1. Is the meal too heavy or too light? Would another salad, dessert or soup give the meal better balance?
2. Avoid a preponderance of starchy foods at any one meal and yet provide sufficient starchy foods.
3. Avoid excessive repetition of any item within the week's menu or on the same days, week after week.
4. Avoid repetition of any item within any one meal.
5. Plan at least one hot item for each meal.
6. Avoid monotony in breads; serve a selection of white, whole wheat, and rye at each meal; serve rolls, biscuits and hot breads as often as possible.
7. Do not forget special sauces, relishes and condiments that complement specific foods. List each item exactly as it is meant to be served.
8. Check days and dates covered by the menu. Have any national or religious holidays been overlooked?
9. Combine soft foods with crisp ones, without a preponderance of either.
10. Combine flavorful foods with bland ones.
11. Consider the probable consumer acceptance of each food item.
12. Describe each component sufficiently, without ambiguity. ■

Menu Components

Individual items which make up the menu should be arranged in a consistent pattern. Present-day menus for hospitals usually list the following components:*

Breakfast: fruit juice, cereal, milk, main dish, bread, butter, beverage.

Dinner and Supper: appetizer or soup, entree (main dish), gravy or sauce, potatoes, vegetables, salad, dessert, bread, butter, beverage.

Before considering the individual components of the menu, two terms, "light meal" and "heavy meal," need explanation, since they have bearing on how the various components are selected.

A heavy meal takes more time to digest than does a light meal. A heavy meal is usually higher in calories and contains fatty foods, whereas for a light meal, the contrary is true. A large number of light items in a given meal can make the difference between a light and a heavy meal.

Some general rules to remember:

With a light meal serve:	With a heavy meal serve:
a heavy soup or	a light soup or
a heavy dessert or	a light salad or
a heavy salad	a light dessert

Appetizers. Appetizers introduce variety and color to the meal and are generally spicy, tart, salty, sour or smokey. Included are: juices, hot appetizers, canapes, marinades, shellfish and relishes.

Soups. Thin soups (light) include consommes, bouillons, broths and essences served with or without garnishes. Thick soups (heavy) include purees, creams, bisques and chowders.

Main Dishes. It is customary in planning the weekly menu to plan entrees of all meals first, then to fill in the accompanying items. Main dishes include meat, eggs, poultry, cheese, vegetables and combinations. There should be a balance between the more expensive items and the less expensive items served during the week. Where a selective menu is used, this balance should apply to each meal. Use of a meatless or meat extended item in combination with a whole meat item is considered good practice.

Sauces. Sauces are used to add color and zest to a dish, but should not disguise the identity of a food item. The sauce selected should complement the natural flavors of the food. In gravies, the base of the gravy should be of the same origin as the item it is to accompany.

Vegetables. Care should be used to select vegetables which add the necessary color, texture and shape required to produce a successful menu. Care should be exercised in using vegetables that have limited appeal. An alternate vegetable should be used with one having poor acceptance.

Salads. Salad is an essential part of every dinner and supper, from a nutritional standpoint as well as because it is a means of adding variety and color to the meal. Salad or combinations of salads may be used to provide light, refreshing entrees during the summer months.

Desserts. Dessert puts the "finishing touch" to the meal. It should be chosen with the same degree of care as the entree and the other components of a meal. Dessert, being the last item eaten, may be responsible for whatever memories of the meal the patient may have. It is an unsolicited publicity agent for the food service department. ■

*Largely based on Arnold Shircliffe's Principles of Cookery. Chicago. Naval Air Technical Training Center, NTSch (cooks and bakers) Navy Pier, 1942,43.

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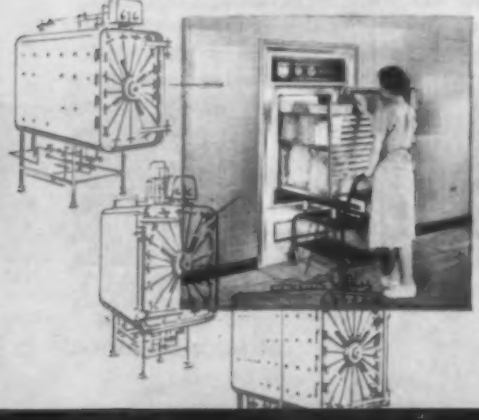

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Kitchen Should Be Clean Enough To Welcome Visitors or Inspectors

Jane Hartman

WHILE it may be impractical to invite patients into the hospital kitchen, certainly every dietitian would do well to plan both the kitchen equipment and production standards for just such a possibility. Nor is this entirely a matter of choice: The Joint Commission on Accreditation of Hospitals — as I have pointed out in previous columns — has been taking increasing interest in both the sanitation and the nutrition programs of hospital dietary departments. It is the Commission's conclusion that too many hospitals have failed to keep their kitchens up to aseptic standards demanded in other hospital departments.

Jane Hartman

Local Sanitarians Can Help

There is another external sanction that increasingly comes into play: the local inspection by sanitarians of the community health department. This is an important trend. The local sanitarian is a trained professional, able to make regular inspections, and available for guidance when needed. He will know local problems of water and milk supply, for example, and thus be in a position to alert the hospital when local problems develop.

The purity of milk and water supply too often are taken for granted. The epidemic of methehemoglamenia in recent years in the Midwest and parts of Canada resulting from high nitrate concentrations in public water supplies represents an extreme example. There are many more prosaic possibilities for contamination of public water supplies. Some hospitals, recognizing these hazards, as well as the possibility of another war, have taken advantage of Civil Defense matching funds to provide their own sources of potable water.

Routine analysis of the hospital water supply by the laboratory department is the only real assurance against both external and inhospital water contamination.

Equally important is the regular checking of milk supplies for purity. It was not many years ago that "properly pasteurized" milk produced a paratyphoid epidemic in one Eastern city that was finally traced to condensate on the pasteurizing kettle covers.

Adequate refrigeration and avoidance of prolonged exposure to room temperatures in the serving process are, of course, basic precautions with milk and milk products. Nothing could provide more harmful public relations for a hospital than an episode of food poisoning from the hospital's own kitchen!

Vermin Control Is Vital

Vermin and rodent control in the hospital is important.

Whether this is done periodically by outside agencies or routinely by hospital maintenance, such a program requires the scientific, *controlled* use of insecticides and poisons, and the accompanying control of receiving and storage systems. Cardboard boxes and vegetable crates are notorious carriers of vermin. Cereals, macaroni, spaghetti and noodles, for example, should be transferred from cartons to

metal containers to protect against dust and infestation.

The dietary storeroom should reflect the highest standards of cleanliness. Patients have a right to expect safe food, and its fitness to eat must be beyond question.

A reliable thermometer is essential wherever foods are stored. Temperatures between 40 F. and 45 F. are desirable for many foods normally kept in the dry food storage area. In order to prevent spoilage and deterioration, temperatures of from 50 F. to 70 F. are recommended for the dry storage area. Good ventilation retards the growth of bacteria and molds, prevents rusting of metal cans, reduces caking of powdered foods, and discourages mustiness. Where the recommended temperatures cannot be maintained by natural and mechanical ventilation, it may be necessary to install artificial refrigeration. If humidities are over 80 per cent, installation of a dehumidifier will be of some help.

Metal Bins Protect Dry Foods

Stainless steel or other metal shelving and bins help keep storage areas sanitary. All supplies should be at least 10 inches off the floor and 12 inches away from the wall for air circulation and to facilitate cleaning. Food must be stored so that older stock is used before newer. Stamp dating of cans or cartons makes good sense.

Bins or cans holding flour, sugar, salt, dried milk, and so on should be emptied and carefully cleaned and dried before additional supplies are put in. The bins should be clearly labeled and mounted on casters to allow easy moving. Grocers' scoops of corrosion-resistant material should be provided for each storage container.

Items that are stored in bags must be stacked on platforms away from walls. Circulation of air around the bags is essential. Swollen cans of fruits or vegetables should be automatically suspect and discarded, as should nuts, dried fruits, and other foods found to be infested.

Although "production" must always be a concern, the necessity of meeting three deadlines a day must never be allowed to interfere with safe sanitation practices in the hospital kitchen. Only the highest standards of cleanliness and sanitation are good enough. ■

Hospital Exhibit Gives Guests a Taste of Nutrition Education, Foreign Cuisine

Mount Sinai Hospital, New York, recently found a way to show off the dietary department and at the same time teach nutrition education.

In recognition of the citywide Nutrition Month this spring, the hospital decided to have a display promoting nutrition education. An international theme representing the foods from major areas of the world participating in the United Nations' food health program seemed to be a good way to bring imagination into the display.

Colored booths were constructed to display the food, cooking habits, and other cultural customs of various countries. The exhibits pointed to some nutritional inadequacies of the various cultures, and at the same time staff members in native costume offered a few of the tempting culinary specialties to cafeteria visitors.

Falafel (a variation of a hamburger) was offered as representative of Israel. Among the other specialties offered were: Japanese sukiyaki, Mexican enchiladas, rice and peas from the Caribbean, and, of course, the traditional American frankfurter.

Directors of the project were Andre Borda, Mount Sinai's director of food services, and Ruth Jeffers, chief dietitian of the nutrition clinic.

In addition to promoting nutrition education, the displays called attention to the scope of the dietary department's activities and the varied backgrounds of its staff, Mr. Borda reported. ■

Marcia Kalin, dietitian, and Andre Borda, director of food services, look on while Dr. M. Steinberg, director of Mount Sinai, gets a taste of Middle Eastern cuisine from Shoshana Schlessinger, a native of Israel.

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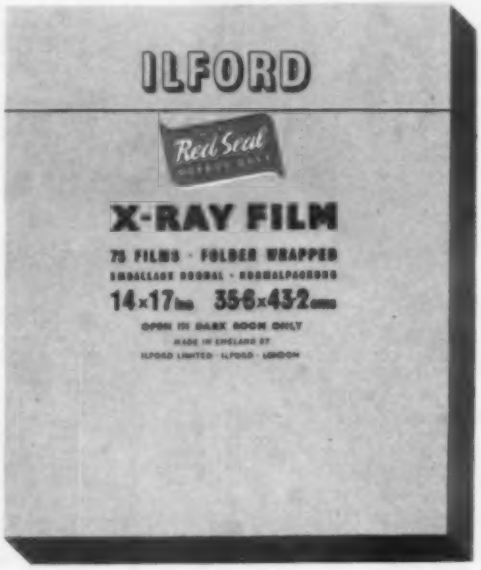

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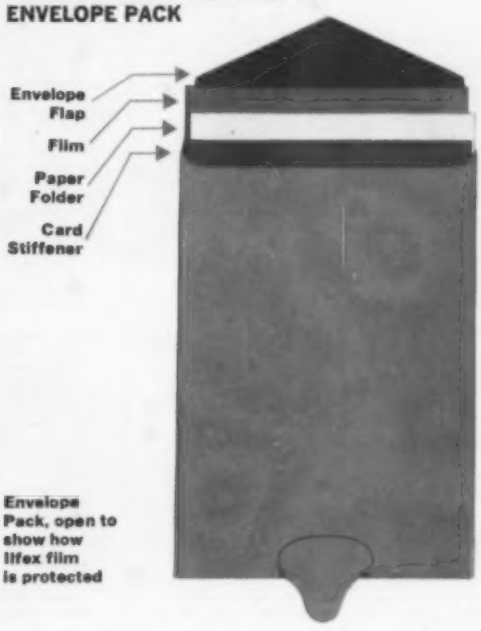

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Menus for August 1961

Louise Slentz
Chief Dietitian
Grace Hospital
Hutchinson, Kansas

1 Grapefruit Half Scrambled Egg • Chicken Noodle Soup Fried Beef Croquettes Mashed Squash Sliced Orange-Pineapple Salad, French Dressing Strawberry Ice Cream • Roast Beef Browned Potato in Juice Buttered Brussels Sprouts Jellied Cranberry- Apple Salad, Dressing Boysenberry Pie	**2** Orange Juice Fried Egg • Cream of Mushroom Soup Grilled Hamburger on Bun, Potato Chips Buttered Peas Sliced Tomato Salad Bread Pudding • Grilled Ham Slice Sweet Potato Puffs Mexican Corn Mixed Fruit Salad Ice Box Cookies	**3** Stewed Rhubarb Bacon, Pancakes • Tomato Bouillon Macaroni and Cheese Buttered Green Beans Tossed Vegetable Salad, French Dressing Orange Concentrate Whipped Gelatin • Chicken Fried Steak Whipped Potatoes Frozen Lima Beans Grapefruit Section Salad Chocolate Ice Cream	**4** Pineapple Juice Soft Cooked Egg • Potato Soup Salmon Patties, Cheese Sauce Buttered Asparagus Jellied Pineapple- Grated Carrot Salad Chocolate Cake • Baked Soie Baked Potato Mashed Squash Stuffed Celery, Carrots Rhubarb Crisp	**5** Sliced Orange Scrambled Egg • Chicken Rice Soup Beef Patty in Mushroom Sauce Glazed Carrots Sliced Tomato Salad Cherry Pie • Swiss Steak Steamed Rice Buttered Broccoli Relish Plate Salad Tapioca Pudding, Whipped Cream	**6** Stewed Apricots Fried Egg • Fried Chicken, Gravy Mashed Potatoes Harvard Beets Cabbage-Pineapple- Marshmallow Salad Banana Split • Cream of Chicken Soup Sandwich Plate, Potato Salad Creamed Peas Applesauce Spice Cake
7 Strawberries French Toast, Sirup • Chicken Rice Soup Beef Stew on Biscuit Buttered Wax Beans Relish Plate Salad Apple Crisp • Baked Liver, Tomato Gravy Buttered Spinach Apple-Grapefruit Salad, French Dressing White Cake	**8** Stewed Prunes Bacon, Biscuits • Tomato Bouillon Tuna Loaf Buttered Peas Molded Whipped Cheese Salad Jelly Roll • Roast Veal, Gravy Mashed Potatoes Buttered Green Beans Mixed Fruit Salad Butterscotch Ice Cream	**9** Grapefruit Half Scrambled Egg • Cream of Pea Soup Italian Spaghetti Asparagus Spears Tossed Vegetable Salad, French Dressing Baked Custard • Spanish Steak Oven-Browned Potato Harvard Beets Jellied Fruit Salad Grapefruit Peach Roll	**10** Cinnamon Applesauce Grilled Sausage Links • Vegetable Soup Creamed Dried Beef, Chinese Noodles Buttered Wax Beans Perfection Salad, Salad Dressing Peppermint Ice Cream • Fried Chicken, Gravy Mashed Potatoes Carrot Julienne Coleslaw Angel Food Cake	**11** Stewed Apricots Oatmeal • Cream of Mushroom Soup Macaroni and Cheese Baked Squash Emerald Salad Oatmeal Cookies • Fried Perch, Tartare Sauce Scalloped Potatoes Buttered Broccoli Waldorf Salad Peach Cobbler	**12** Stewed Rhubarb Soft Cooked Egg • Cream of Celery Soup Creamed Chicken on Chinese Noodles Glazed Carrots Sliced Tomato Salad Strawberry Shortcake • Breaded Veal Cutlet Creamed Diced Potato Asparagus Spears Tossed Vegetable Salad, French Dressing Pineapple Cream Pudding
13 Grapefruit Half Cinnamon Roll, Bacon • Baked Ham, Raisin Sauce Glazed Sweet Potato Buttered Broccoli Spring Salad, French Dressing Vanilla Ice Cream • Potato Soup Meat Loaf Buttered Green Beans Molded Peach-Grape Salad Pumpkin Pie	**14** Stewed Rhubarb Scrambled Egg • Cream of Chicken Soup Fried Cheese-Rice Croquette Whole Kernel Corn Relish Plate Salad Raspberry Gelatin With Whipped Cream • Baked Veal Cutlet Hash Brown Potatoes Creamed Carrots Jellied Fruit Salad Butterscotch Brownies	**15** Tomato Juice Poached Egg • Chicken Noodle Soup Beef Patty Spanish Tomatoes Waldorf Salad Pineapple Scones, Whipped Cream • Roast Beef, Gravy Whipped Potatoes Buttered Wax Beans Tossed Vegetable Salad, French Dressing Vanilla Ice Cream	**16** Grapefruit Half Fried Egg • Cream of Tomato Soup Veal Loaf Buttered Spinach Pineapple Salad Chocolate Pudding • Grilled Canadian Bacon Glazed Sweet Potato Buttered Asparagus Molded Waldorf Salad Baked Custard	**17** Stewed Prunes Oatmeal • Vegetable Soup Hot Roast Beef Sandwich Buttered Green Beans Sliced Tomato Salad Peppermint Ice Cream • Broiled Steak Dutchess Potatoes Cream Style Corn Head Lettuce Salad, 1000 Island Dressing Apple Pie	**18** Grapefruit Sections Poached Egg • Tomato Bouillon Tuna-Noodle Casserole Buttered Broccoli Pear-Cottage Cheese Salad Burnt Sugar Cake • Broiled Trout Baked Potato Whole Kernel Corn Cabbage Pimiento Salad Butterscotch Pudding
19 Stewed Apricots French Toast, Sirup • Potato Soup Spanish Beef-Rice Casserole Harvard Beets Molded Applesauce Salad Fruit Bars • Roast Pork, Gravy Mashed Potatoes Stewed Tomatoes Cherry-Gelatin- Grapefruit Salad Chocolate Cake Pudding	**20** Frozen Strawberries Sausage Links, Biscuits • Breaded Steak Oven-Browned Potato Buttered Peas and Carrots Tossed Vegetable Salad Cherry Pie • Vegetable Soup Turkey a la King on Biscuit Buttered Asparagus Molded Health Salad Chocolate Ice Cream	**21** Stewed Prunes Bacon, Doughnut • Cream of Tomato Soup Chicken Noodle Casserole Buttered Spinach Waldorf Salad Chocolate Brownies • Breaded Pork Chop Creamed Potatoes Cream Style Corn Tossed Vegetable Salad Graham Cracker Pudding	**22** Grape Juice Poached Egg • Beef Broth Chinese Omelet, Mushroom Sauce Breaded Tomatoes Tossed Vegetable Salad, 1000 Island Dressing Royal Ann Cherries • Swiss Steak Whipped Potatoes Buttered Peas Carrot-Pineapple Salad Orange Cake Pudding	**23** Sliced Oranges Baked Egg Casserole • Vegetable Soup Beef Roll, Gravy Buttered Beets Jellied Pear-Cottage Cheese Salad Plum Cobbler • Baked Steak Scalloped Potatoes Buttered Wax Beans Sliced Tomato- Cucumber Salad Strawberry Ice Cream	**24** Cantaloupe Half Scrambled Egg • Tomato Rice Soup Baked Liver Buttered Carrots Mixed Fruit Salad, Honey French Dressing Vanilla Cream Pudding • Meat Loaf Potato Balls Succotash Cottage Cheese Salad Whole Peeled Apricots
25 Pineapple Juice Soft Cooked Egg • Mushroom Soup Fruit-Cottage Cheese Plate Buttered Whole Kernel Corn Toasted Cocoanut Cake • Baked Haddock Steaks Potatoes au Gratin Frozen Lima Beans Orange Waldorf Salad Grapefruit Gelatin	**26** Grapefruit Half Poached Egg • Chicken Noodle Soup Meat Balls in Tomato Sauce Buttered Asparagus Pineapple-Cottage Cheese Salad Strawberry Bavarian • Turkey a la King Mashed Sweet Potatoes Frozen Peas Tossed Vegetable Salad Date Cake, Whipped Cream	**27** Tomato Juice Coffee Cake • Chicken Broth Roast Turkey, Gravy Mashed Potatoes Buttered Brussels Sprouts Mixed Fruit Salad Chocolate Ice Cream • Cream of Pea Soup Sandwich Plate Whole Green Beans Fruit Gelatin Cherry Pie	**28** Stewed Apricots French Toast, Sirup • Beef Noodle Casserole Cheese Fondue Stewed Tomatoes Combination Salad, 1000 Island Dressing Peach Halves • Ham, Pineapple Sauce Sweet Potato Balls Cauliflower Apple-Grapefruit Sections Chocolate Cake	**29** Mixed Fruit Juice Baked Egg Casserole • Tomato Bouillon Turkey and Rice Buttered Spinach Spring Salad, French Dressing Baked Apple • Roast Veal, Gravy Mashed Potatoes Buttered Carrots Stuffed Prune Salad Butterscotch Pudding	**30** Banana Poached Egg • Beef Broth Chicken Loaf Buttered Succotash Head Lettuce With French Dressing Burnt Sugar Cake • Minute Steak Baked Potato Green Beans With Bacon Sliced Orange Salad Chocolate Chiffon Pudding
31 Cinnamon Applesauce, Scrambled Egg • Vegetable Soup, Creamed Ground Beef on Rusk, Buttered Asparagus, Sliced Tomato Salad, Gingerbread With Whipped Cream • Roast Beef, Gravy, Mashed Potatoes, Buttered Frozen Peas, Cardinal Salad, Blue Plums. Ready-to-eat or cooked cereal served on all breakfast menus.					

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40 Ways To Engineer Plant Savings

These new methods and materials can save money — and make the plant engineer's job easier

J. A. Millard

A WELL rounded mechanical and safety education program, which includes doctors and nurses, can do more to reduce operating and maintenance costs than almost any other hospital policy. The hospital engineer, therefore, can probably do as much as any person in the organization to reduce the cost of patient care through operating economies.

But if he is to do this, the engineer must probe and analyze constantly to find new methods and materials that may result in savings.

Here are some ideas the engineer might investigate to reduce costs and effort. Not all of them, of course, will apply in every hospital — but they are intended to stimulate thinking in terms of the needs and problems of individual hospitals.

---

1 How much electricity is used per patient day? A continuous curve plot showing power factor, kilowatt demand, and kilowatt hours consumed each month will establish a pattern and indicate excess use or loss of electric power.

2 What is the hospital's electric "power factor"? If it is less than 97 per cent, it will pay to install capacitors on the electric system. It may be possible to reduce the electric bill 10 to 25 per cent, depending on the power factor. The capital investment to correct the power factor can be recovered in less than two years from savings obtained.

3 It may be more economical to provide full standby electric power than to provide emergency light and power circuits, which serve only part of the hospital.

4 An in-floor duct system saves space and cuts cost of new construction.

5 All low voltage (60 volts and under) and electronic circuits can be installed in a common duct system, reducing conduit installation cost.

6 The administrator as well as the engineer should know what items of electronic equipment are used in the hospital. It may pay to have a maintenance man trained in the fundamentals of electronic equipment.

7 A portable ampmeter is useful to check for overload or low voltage at specific times on electric motors and other circuits.

8 All electric equipment and appliances must be grounded for safety.

9 Having the proper tools and equipment for simple electric welding can save money.

10 How much water is used per patient day? A continuous curve plot showing gallons of water consumed each month will establish a pattern and indicate excess use or loss of water.

11 Exposed hot water, steam and return lines, and inadequately insulated lines result in costly heat loss. Insulation should be checked regularly.

12 Automatic controlled zoned heat can save 20 to 35 per cent of fuel cost to heat a building.

13 Piping problems are simplified with high-pressure, high-temperature hot water distribution heating system.

14 Use of portable pyrometer to check steam traps can save time and money.

15 A stethoscope with a ⅜ inch brass rod attached to the metal receiver offers an easy way to

(*Continued on Page* 124)

Mr. Millard is a hospital consulting engineer, Lima, Ohio.

• The safety and success of anesthesia depend on more than the gas alone.
In addition to the skill of the administering professional, safe and successful anesthesia depends on three important factors: gas purity . . . cylinder interior cleanliness . . . valve performance.

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Mr. Robert R. Shields, Administrator, Williamsburg Community Hospital, Williamsburg, Virginia, says:

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HOSPITAL OPERATING ECONOMY MAY DEPEND ON MANY SMALL SAVINGS, SUCH AS THESE

(*Continued From Page* 120)

check steam traps. Place the end of the rod on the trap and listen to it operate. A longer rod can be used to check ceiling or floor traps easily. The stethoscope can also be used to locate water leaks.

16 Correct selection of steam traps is important for economy of operation.

17 The temperature of the cold water supply can be raised 60 F. by recovering waste heat from laundry and dishwashing dump. The capital investment for a heat recovery system can be recovered in less than two years.

18 Waste heat from the incinerator can be used to heat hot water or, in some cases, generate steam. In this way boiler demand can be reduced approximately 0.1 boiler horsepower per patient census during peak load.

19 Steam boiler capacity can be increased by installation of a heat exchanger between boiler and feed water pump, recovering loss heat from condensate, flash steam, or from flue gases in the boiler breeching.

20 A dearator, which removes excess oxygen in boiler feed water systems, can stop corrosion or pitting of boilers and pipes.

21 Boilers should be kept clean; a dirty boiler may consume 25 to 50 per cent excess fuel.

22 Too much air in the boiler will force unused heat up the chimney or flue. Too little air will cause the boiler to soot, which reduces its efficiency.

23 The hospital should have a continuous record of the cost per pound of steam as an administrative guide to show if the boilers are being operated efficiently.

24 Authenticated service records provide evidence of the ability of wrought iron to eliminate early repair and decrease over-all maintenance costs by increasing the life of steam condensate installations.

25 Establish a standard for all painting and colors. The right paint in the right place can reduce maintenance costs.

26 Acoustical ceilings can now be installed at a savings over plaster ceilings in new construction. They also offer lower maintenance cost.

27 Ceramic glazed structural tile cove base is more economical to install than terrazzo cove base.

28 Ceramic acoustical structural tile blocks are now available and are practical for hospitals.

29 Ceramic glazed structural tile design and construction add environment and reduce maintenance costs.

30 Vinyl floor tile reduces noise and will outwear asphalt floor tile. The savings in floor wax alone will pay for the additional cost of vinyl tile within five years.

31 Storage space can be doubled without using more floor area by the use of efficiently designed metal racks.

32 More efficient and sanitary distribution of ice is possible with individual ice making machines located at each nurses' station.

33 Theft-proof toilet tissue holders are available that can save money. The selection of the right type of paper towels and dispensers can also save money.

34 Disposable paper wash cloths are practical and economical for patient use.

35 Inexpensive, disposable blankets made of 22 layers of crepe paper are being used in Swedish hospitals to replace woolen covers, which have a tendency to collect dust and germs.

36 The hospital engineer is the logical person to control keys, and he should institute a key control and index system. The hospital should have its own key cutting machine.

37 Battery operated floor scrubbing and polishing machines can save money by enabling one man to do more and better work than four men using conventional equipment.

38 In the laundry, zero soft water can reduce the cost of soap and detergents by 50 to 75 per cent, depending on the grains of hardness. Just three or four grains of hardness will greatly increase laundry washing time and soap consumption.

39 A spreader on the laundry flat ironer will enable one girl to shake and deliver more sheets per hour than three or four hand shakers.

40 Automatic folders and finishing units increase laundry press production without increasing labor cost.

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Psychology Is Nothing If Not Practical

Continuing the series of lectures on

Administrative Housekeeping for Institutions

Mildred L. Chase

IN THE third article of her series on "Administrative Housekeeping for Institutions," Mrs. Chase discusses the practical application of psychology in enlisting the interest and cooperation of housekeeping employes in the administrative housekeeper's efforts to improve her service. As was pointed out in the introduction to the series, the lectures that appear in this and succeeding issues are presented as topical outlines rather than formal exposition and include a minimum of explanatory text. Hence the housekeeping instructor can adapt the materials to her own use and elaborate on the various points as the needs of the class and her own experience in administrative housekeeping dictate.

Next month's lecture will cover the principles of personnel administration.

PEOPLE can be handled correctly only when the executive has acquired a knowledge of how to investigate the behavior of each individual. It is important.

1. All executive action is carried out by people:

The wise handling of men can mean the success or failure of the department head.

You must be able to arouse the individual initiative of the men working under you.

Your dealings must be human if they are to succeed.

A knowledge of people is necessary.

2. There is a difference between having people work with you and for you:

Call your employe a working partner and make him feel like one.

Strip aside the trimmings and let the ability of the employe be weighed.

Talk sincerely — not just glibly.

3. Ability to see a problem from the other fellow's standpoint and to harmonize conflicting points of view will help you gain knowledge:

Studying the methods of dealing with people who know more than you do will help you gain knowledge of others' behavior.

First Principle of Human Nature

The first and deepest principle of human nature is learning what is at the bottom of their thinking, thus causing their behavior.

1. Understanding, like dealing with people, is an art:

It can be the most useful art in business.

It can be the most valuable art in living.

Try to understand the underlying principles on which their thoughts are based.

Practice incessantly the application of this understanding in all dealings and relations with your people.

2. Each person is, and regards himself as, the center of his own world of experience and action:

Thus the employe is concerned with himself first and foremost.

The employe feels that everything he does is centered in and around himself.

Prove this easily by finding out his uppermost thoughts and worries.

He may *think* that nothing in the universe equals the object of his affections, but, in actuality, he, himself, comes first.

3. Investigate his interest and find out what "I" wants:

Food — to keep the fires of life burning.

Comfort — to retain health and well-being.

A mate — for companionship and continuity of life.

Power — for achievement and control of environment.

Approbation — for prestige and recognition among your fellows.

4. Motivation through the principle of self-interest is the core of the art of understanding and dealing with people: (*Cont. on Page* 128)

Mrs. Chase is director of housekeeping services, Glendale Sanitarium and Hospital, Glendale, Calif., and director of the housekeeping course at Los Angeles Metropolitan College of Business.

(*Continued From Page* 126)

An understanding of what makes people think and feel and act as they do determines whether we use compulsion – a method of slavery – or suasion – a method of free men.

Basic Technics

Use these basic technics to further your investigation of behavior:

1. Respect, investigate and deal with each person as a person.

To be a man among men is man's deepest wish.

(a) The desire to be important is the deepest urge in human nature.

(b) Try to understand how to deal with each person so as to make him feel he is the center.

Show him that you have respect for him as a person:

(a) He will immediately give out in such a way that you will gain a better understanding of his nature.

(b) Never humilate him by ignoring him. He will retreat into silence.

(c) Never be snobbish. He will feel he can never get to your level and will remain a closed book to your understanding.

2. Show genuine interest and understanding in his home-life or hobbies:

A display of interest in a hobby will get a man talking faster than any other type of questioning. Show less knowledge of the subject than he indicates, and he will feel freer to talk.

3. Indicate your confidence in the employe's ability and integrity.

Let him know you believe he can do just a little better than he thinks he can.

By showing this trust, you will, at least, bring out the best in him.

Never be afraid to ask for his help, advice or favor to bring out his thoughts on immediate problems that might have aroused questionable behavior.

Invite his confidence when he seems to have accepted you as a friend.

Indicate your high expectations and watch for his reactions.

Morale is defined as: "Prevailing mood and spirit conducive to willing and dependable performance, based upon a conviction of being in the right and on the way to success and upon faith in the cause or program."

To study what it really means, we can break it down this way:

Opinions

1. Expressions of a person's attitudes:

(a) Generally quite specific.

(b) Fairly easy to discover.

2. An employe asked the following questions can generally express his opinions on these matters with a simple "yes" or "no" answer:

(a) Is he satisfied with his pay.

(b) Is he satisfied with the way the pay is administered.

(c) Is he satisfied with his pay as compared to that of other employes.

Attitudes

1. A predisposition to behave in a certain way because of:

(a) Previous experience.

(b) Information.

2. More generalized than opinions:

(a) The "soil" in which opinions grow.

(b) Favorable opinions on specific questions generally mean the attitude is quite favorable.

Morale

1. The total of attitudes and opinions:

(a) Although it is an abstraction, this allows us to grasp its meaning.

(b) We can differentiate between "high morale" and "poor morale."

2. Represents the condition of sound human relations in an organization:

(a) Workers cooperate.

(b) They are willing to interpret institution's actions in a favorable light.

(c) They are loyal to the organization.

(d) They can see humor in administrative errors.

3. Morale survey can show that there is, or is not, a problem in a specific area.

It points out areas in which employes are ignorant of policy or fact:

(a) Benefit programs.

(b) How to communicate.

(c) Areas for their use.

It helps management to see itself as the employes see it:

(a) Tend to help management improve its decision making.

(b) Helps them to formulate policy.

(c) Helps them communicate facts.

It gives administrative people the accurate picture of the state of employe morale:

(a) Attitudes can be safely revealed.

(b) It is a relief to get things out in the open.

(c) Sometimes employes don't know what they are giving away.

It demonstrates administration is interested in how employes feel:

(a) Follow-up action can lead to increased cooperation.

(b) Brings the different levels closer together.

Service workers (which includes housekeeping workers) belong to the general morale level of 35 – about the same as that of routine production workers. Hospital and hotel service workers, however, have lower morale than is typical of service workers in industry doing a similar type of work. They react unfavorably to job demands, *i.e.* pressure, workload, hours, personal relations with management people (they rarely see them or rarely hear from them directly).

A recent survey with both professional and service hospital personnel revealed that employes with poor supervisors have the following attitudes:

1. My pay is too small to live on.

2. What about these long hours we have here?

3. We should have more money and shorter hours.

4. This hospital is truly a slave driver as far as hours and salary are concerned.

5. I find a question in my mind as to the fairness of the administration in dealing with its employes.

6. Every employe should have a chance to talk to someone higher up to be sure he is understood.

Another hospital with good supervisors elicited these answers from employes:

1. The hours of work around here are O.K.

2. My boss sees that employes are properly trained for their jobs.

3. I know how my job fits in with other work in this organization.

This shows that employes need and expect:

1. Better communications – just make explicit exactly what is expected.

2. A clear outline of the "benefit package" to help in motivating employes.

3. Supervisors to encourage new ideas and understand their special responsibility as counselors.

4. Their status built up through management's recognition. ■

For additional information, use postcard facing back cover.

McNerney Likes To Get Things Moving

(*Continued From Page 64*)

ciation, American College of Surgeons, American College of Physicians, and the Southwestern Michigan Hospital Council.

Elsewhere, he has urged prepayment groups "to set their own criteria of quality and police their standards."

McNerney has little patience with those who argue that overutilization has only a small impact on the cost of hospital care. To him, that argument misses the point. "Because hospitals operate under close public scrutiny," he maintains, "it is proportionally more important for them to give providers of care overt evidence that they are operating within reasonable grounds — even though the criticisms of hospitals may be on the basis of allegation rather than fact."

Earlier, in a cool, objective appraisal[2] of Blue Cross-Blue Shield, McNerney suggested that the trouble now faced by the Plans "is due in part to management defaults" and to what he described as "a posture that became somewhat defensive because of constituent pressure."

Off his record, it is abundantly clear that McNerney has no intention of taking such a defensive stance. In the language of that man in Washington, he appears determined to get the prepayment plans moving forward again, pulling those who would stand pat along with him.

"I don't think you'll find Mac making a lot of little mistakes," says a Minnesota University classmate. "If he makes an error, it'll be a big one. He's bold and courageous in his thinking and he's not afraid to go for broke."

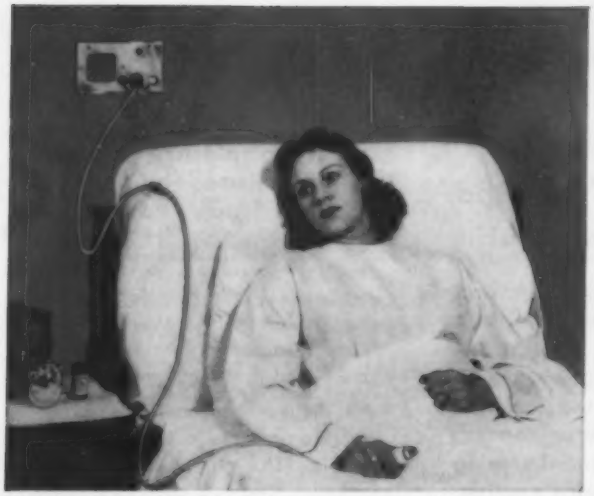
It seems certain that Blue Cross leaders were aware of these characteristics when they selected him. This could mean that they, like McNerney and many others in the health field, feel that now is the time to launch an all-out effort to preserve and improve the voluntary prepayment system.

If that turns out to be the case, foes and critics of Blue Cross had better roll up their sleeves, do some wind sprints and roadwork — and lots of homework.

They're in for a battle. ■

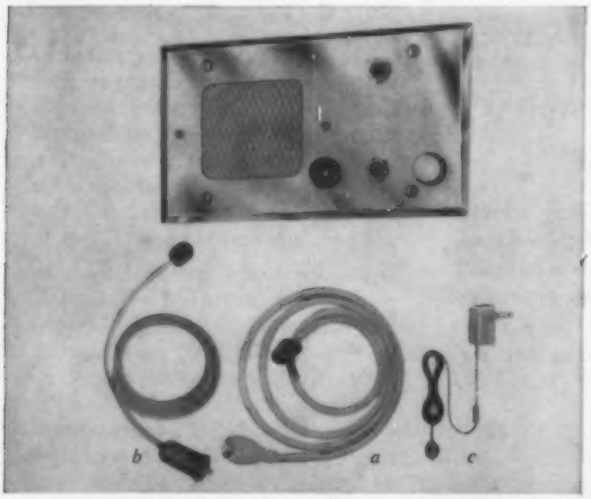
— AARON COHODES

[2]Walter J. McNerney: Why Blue Cross Is Changing Its Plans, Mod. Hosp. 75:95 (October) 1960.



▲ *The patient may talk to the nurse—even whisper—from any position in her bed.*

▲ *The nurse may talk to patients from her station, monitor their rooms, cancel their signals.*



▲ *Interchangeable cord sets for calls from: a. normal patients; b. patients who cannot speak or hear; c. oxygen-tent patients.*

▲ *Remote reply units enable the nurse to accept calls and talk to patients from locations away from her station.*

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The Modern Hospital News Digest

Full Circle

Philadelphia Medical Society Changes Its Mind; Replaces Barrier Between M.D.'s and Osteopaths

PHILADELPHIA. — The obstacles between D.O.'s and M.D.'s are up again here. They were put back in place by members of the Philadelphia County Medical Society, who last month voted 171 to 115 against working with doctors of osteopathy. Earlier, the society's board of directors had voted to recognize osteopaths and abolish ethical restrictions against collaborating with them. The new vote rescinded the board's action. ■

Strike Three

Three Chicago Doctors Dropped From Staff for Failure To Pay Building Assessment

Three doctors who balked at paying to stay on the team have been dropped from the staff of Grant Hospital, Chicago, reportedly for failure to pay a building fund assessment. One Grant staff doctor thought they were way off base. He commented: "If they don't want to play ball in our ball park, let them find another one." ***(See Page 142)***

Seek New Technics and New Thinking, Speakers Urge Catholic Hospital Delegates

The importance of methods improvement to the survival of voluntary hospitals was stressed at the Catholic Hospital Association convention in Detroit, June 12 to 15. Speakers from industry and universities joined with hospital administrators in urging adoption of new technics in management. ***(See Page 88)***

When the Lights Went Out, Emergency Power Kept Hospitals From Being in the Dark

NEW YORK. — The way hospitals met the emergency was one bright spot in the blackout that affected a large area of the city June 13. Hospital standby generators and police emergency service supplied needed power, the affected hospitals reported. In most, surgery and food preparation had been completed before the power failure. No serious problems were noted. ■

Most Hospitals Are Unable To Relate Rates to Costs, Michigan Study Indicates

ANN ARBOR, MICH. — Hospital accounting procedures in this state are still weak, according to researchers at the University of Michigan.

They recommend that Blue Cross take the lead in strengthening them.

After studying accounting and business office practices in 46 general hospitals in Michigan, the researchers found that little cost analysis is being undertaken in them and that "most hospitals are unable, even if they desire, to relate rates to costs. . . ."

The investigators, who reported to the Governor's Commission on Pre-Paid Hospital Care, urged hospitals to stop overpricing some services and underpricing others. Instead, they said, hospitals should set rates for each service that "recover full cost and earn a reasonable profit."

The study also criticized the current contract between Blue Cross and hospitals, which "places the hospital in the position of being paid for much of its services at prices set by its largest customer."

The investigators recommended that the contract should be rewritten to "include the terms and methods of payment" and "provide adequate and equitable payment for services supplied to subscribers."

They indicated that hospitals and Blue Cross should be able to adopt a satisfactory method of payment based on precise cost determinations for covered services in "a reasonable period of time, possibly two to three years."

If they don't, the investigators said that the state insurance commissioner should step in and "prescribe that a suitable method of payment and cost determination be implemented."

In their list of 38 specific recommendations on this subject, the researchers urged the Michigan Hospital Association to develop a "uniform reporting mechanism to be used by all hospitals" and a program "to aid those hospitals lacking the skills needed to collect and process necessary data." (*Continued on Page* 138)

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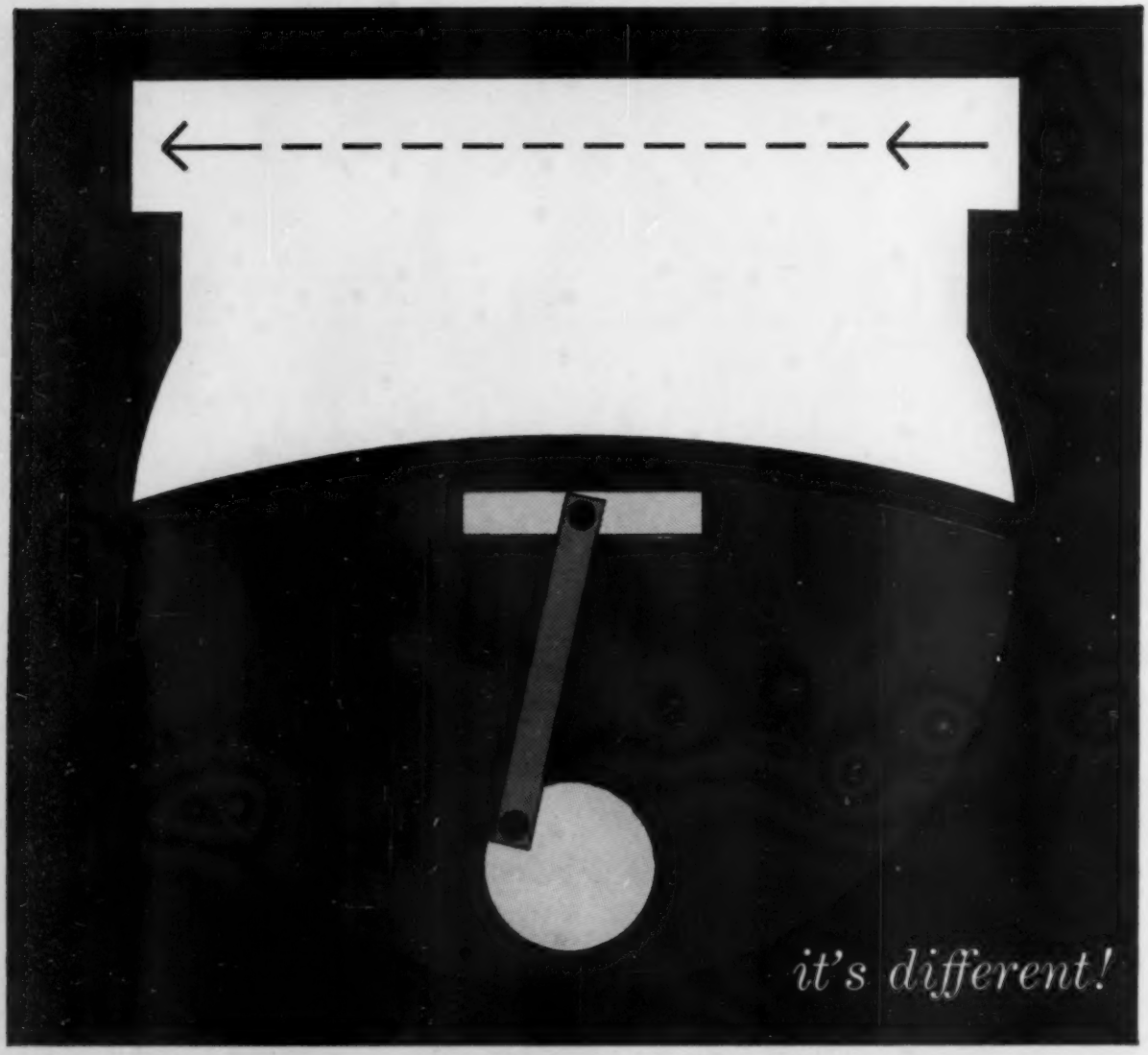

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Generic Prescribing Saves Only a Little, Pharmacy Firm Executive Reports at Forum

BROOKLYN, N.Y. — Alleged savings to be gained through prescribing drugs by generic rather than trade names simply don't emerge in actual practice, it was asserted here last month at a public health forum sponsored by Brooklyn College of Pharmacy, Long Island University.

"If universal generic prescribing were enforced, the savings to the consumer would be somewhere between 2 and 7½ per cent," Francis Boyer, chairman of the board, Smith Kline & French Laboratories, told the group.

Mr. Boyer reported a field survey of 20 widely used prescription specialties.

"Of the 20, three were mixtures — and I know of no practical way of giving generic names to mixtures," he reported.

In addition, 13 of the 20 prescription items were patented, the speaker added, making it unlikely that generic name prescribing would result in any price reduction.

"Out of this list of 20 top sellers, there were only four which had any even theoretical generic equivalents, or where any saving was likely under generic prescribing," Mr. Boyer concluded. "This fact made the alleged savings look pretty doubtful, so we made an actual field survey of items which were available under both brand and generic names. In one of these, the generic prescriptions showed an average saving of 11 per cent and in the other the saving was 12 per cent.

"Finally, we made an estimate of the total picture and concluded that

(*Continued on Next Page*)

Administrative Residencies Announced by Columbia

NEW YORK. — The following residencies in hospital administration have been announced by Columbia University School of Public Health and Administrative Medicine:

Bruce J. Baust to Mount Auburn Hospital, Cambridge, Mass.; Harris J. Brodsky to Barnert Memorial Hospital, Paterson, N.J.; Donald A. Cramp to Montefiore Hospital, New York; Francis Harrington to Hackensack Hospital, Hackensack, N.J.

Henry Manning to Brooklyn Hospital, Brooklyn, N.Y.; Howard H. Moses to Hunterdon Medical Center, Flemington, N.J.; John P. Noble to Hospital Council of Greater New York and U. S. Public Health Service Hospital, Staten Island, N.Y.; Harlow Russell to Grasslands Hospital, Valhalla, N.Y.

Robert Tell to Beth-El Hospital, Brooklyn, N.Y.; Benjamin F. Webster to Ellis Hospital, Schenectady, N.Y.; Kenneth N. Wenrich to Jefferson Medical College Hospital, Philadelphia.

First row, l. to r.: W. Landis, Raymond P. Sloan (faculty), Sister St. Ernestine, H. Baumgarten (faculty), F. Harrington. Top row: H. Brodsky, R. Tell, K. Wenrich, H. Russell, J. Noble, B. Webster, D. Cramp, H. Manning, B. Baust.

(Continued From Preceding Page)
if universal generic prescribing were enforced, the savings to the consumer would be somewhere between 2 and 7½ per cent."

Mr. Boyer also reported a study conducted by the Division of Public Assistance of the state of Rhode Island, in which 10,000 prescriptions for welfare recipients were examined to determine the actual savings to the department of generic as opposed to trade name drugs.

As it turned out, substituting generic drugs wherever possible would have provided a saving of less than 5 per cent, it was reported.

Mr. Boyer also reported on studies demonstrating that "generic equivalents" are frequently not equivalent at all.

"Two of our prescription specialties were shopped in a statistically significant number of stores in several cities, roughly half of the prescriptions being written for the brand name and half for the generic name," he related. "When these drugs were analyzed, the active ingredient content of the so-called generic equivalents was found to fall outside the extremes of tolerance established by the U.S. Pharmacopeia in 35 per cent of the cases, whereas all samples of the branded products were of top quality.

"The theory 'equally good products at a great saving to the patient' remains a theory, in complete opposition to the facts. This being so, it would seem obvious that most physicians will be reluctant in their normal practice to give up brand name prescribing. Their patients save very little money, and they run an appreciable risk of getting substandard medication."

Michigan Study

(*Continued From Page* 132)

In another report undertaken as part of the Michigan Study of Hospital and Medical Economics, researchers recommended:

1. Construction of a new medical school in Michigan, preferably in Grand Rapids.
2. Expansion of Wayne State University's medical school so it can accommodate 200 first-year students.
3. Enlarged educational programs for virtually all types of health personnel, including dentists, to help overcome shortages.

In a third report released as part of the study, a research team reported that nearly three-quarters of the increase in short-term hospital costs from 1950 to 1958 stemmed from inflation (34 per cent) and increased utilization (40 per cent).

Although the researchers found an unmet need for 41,635 additional hospital and nursing home beds, they also found that "too many hospitals are built without the benefit of area-wide surveys."

The researchers also found that 97 short-term general hospitals in the state with a total of 3917 beds did not qualify for accreditation by the Joint Commission on Accreditation of Hospitals. "Of these," their report said, "23 hospitals with 613 beds were so far below the threshold that accreditation in the foreseeable future was deemed unlikely."

The study urged purchasers of health care to measure the quality of the care they are paying for "both as a stimulus to individual hospitals and to give overt evidence of public concern."

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Chicago Announces 14 Resident Appointments

CHICAGO. — The following residency appointments have been announced by the University of Chicago's graduate program in hospital administration. Students and the hospitals to which they are assigned are:

Joe M. Dickson to Shannon West Texas Memorial Hospital, San Angelo, Tex.; Leonard L. Genung to Iowa Methodist Hospital, Des Moines; Richard E. Gillock to Evanston Hospital, Evanston, Ill.; Charles M. Green to North Carolina Baptist Hospital, Winston-Salem.

Pankey G. Hall to Baylor University Medical Center, Dallas, Tex.; Ramon Linares to University Hospital, Ohio State University, Columbus; William T. McClintock to Highland-Alamada County Hospital, Oakland, Calif.; Jane Nemoff to the University of Chicago Clinics.

Peter H. Sammond to University of Illinois Research and Educational Hospital, Chicago; Lt. Theodore Scheihing to U.S.A.F. hospital, Wright-Patterson Air Force Base, Ohio; Glenn Seiler to University Hospital, Baltimore.

C. Thomas Smith Jr. to Baptist Memorial Hospital, Memphis, Tenn.; Jack W. Weiblen to Memorial Hospital of Long Beach, Long Beach, Calif.; John R. Wheeler to University Hospitals of Cleveland, Cleveland.

Top row, left to right: faculty members, Vernon Forsman, James Connelly, Ray E. Brown (director), Irvin Wilmot. Middle row: Joe Dickson, William McClintock, Peter Sammond, John Wheeler, Charles Green, Lt. Theodore Scheihing. Bottom row: Richard Gillock, C. Thomas Smith, Leonard Genung, Ramon Linares, Jane Nemoff, Pankey Hall, Jack Weiblen.

Talks Give Administrators a Look in Hospital Future at Upper Midwest Meeting

ST. PAUL — Because of the many facets of the modern hospital, all leading up to better and more effective care of the patients, hospital administrators must be increasingly skillful, Richard L. Johnson, assistant director of the American Hospital Association, told a large audience at the Upper Midwest Hospital Conference here recently.

He said that since hospitals are big business — the fifth largest industry in the country — it is important that the principles of management apply to their operation. These include adequate financing and good organization, he said.

Other general sessions in the conference, which attracted more than 4500 delegates, were devoted to home and nursing home care, strategy in administration, the right mental attitudes for hospital employes, and application of electronics and automation to hospitals.

Highlighting the final general session, Dr. Ian Brown, St. Paul neurologist, explained an electronic monitoring system capable of taking and recording the temperature, pulse rate, respiration rate, and blood pressure of up to 16 patients at the same time.

Dr. Brown envisioned a hospital era

(Continued on Next Page)

Officers Get Together at Two Regional Meetings

Officers of the Midwestern Hospital Association shown above are, left to right: president-elect, Carl C. Lamley, executive director, Stormont-Vail Hospital, Topeka, Kan.; president, Carlos J. R. Smith, administrator of Helena Hospital, Helena, Ark.; retiring president, C. E. Copeland, administrator of Missouri Baptist Hospital, St. Louis.

E. E. Cavaleri, left, was installed as president of the Southeastern Hospital Conference at the annual assembly held in Memphis, Tenn. Mr. Cavaleri is administrator of Crippled Children's Clinic and Hospital, Birmingham, Ala. Raymond C. Wilson, right, administrator, Southern Baptist Hospital, New Orleans, is the president-elect for 1961-62.

(*Continued From Preceding Page*)
15 years hence when machines automatically will handle admissions and hospital bookkeeping, when computers will aid in diagnosis, and when anesthesia will be controlled electrically.

Jack L. Rogers, administrator of Sioux Valley Hospital, Sioux Falls, S. D., succeeded J. E. Robinson of Children's Hospital, Winnipeg, Manit., as president of the regional conference. New president-elect, to take office in 1962, is James A. Anderson, administrator of Lutheran Hospital, Fort Dodge, Iowa.

Present and future converged as (l. to r.) Jack Rogers, president, Glen Taylor, executive secretary, and James A. Anderson, the president-elect got together to discuss the future of the Upper Midwest Hospital Association at annual meeting.

Three Doctors Dropped From Staff Over Issue of Building Assessment

CHICAGO. — Whether three doctors were compelled to contribute to a hospital building fund as a condition of keeping their staff appointments is the issue brought before the Chicago Medical Society last month.

The three doctors were dropped from the staff of Grant Hospital here, reportedly for their failure to pay a medical staff assessment for the hospital's building fund.

The Chicago Medical Society is investigating the charge and has turned over to a fact-finding committee the doctors' petition asking that the medical staff leaders of Grant Hospital be charged with unethical conduct and that the hospital lose its accreditation, the *Chicago Daily News* reported.

Norton L. Penney, an attorney on the board of the hospital, said the assessment was a voluntary act of the medical staff designed to obtain an income tax advantage.

The quota for each doctor was determined by his staff ranking, with attending physicians to contribute $3000, associates, $2000, and courtesy staff, $1000.

The tax advantage, it was explained, results from the fact that, as voluntary giving, the amount could only be grouped with other charitable deductions. As an assessment, it could be listed as a "cost of doing business" and afford a tax saving.

Mr. Penney said the decision not to reappoint the three complainants was made by the medical staff executive committee.

The refusal of the three to pay embittered other staff doctors, the *Daily News* reported.

One of the doctors commented: "The hospital is their workshop. They are obligated to support it. If they don't want to play ball in our ball park, let them find another one."

The A.M.A. house of delegates had expressed a different view of compulsory giving at its last convention in Miami. A resolution adopted then stated:

"Neither the hospital management nor the medical staff has the privilege or right to make compulsory assessment of the members of the medical staff for building funds . . . as a requisite for staff appointments."

Can you afford to give away medication?

As hospital costs mount, it is becoming increasingly evident that the beneficiaries of hospital services—the patients—must assume their fair share of the costs incurred. For this to occur, the hospitals must be able to account scrupulously, either to the patients or to the various prepaid hospital plans, for all services and medication.

Old-style injections too complicated

Because accounting and billing for medication withdrawn from multidose vials has been so difficult and time consuming, many hospitals have virtually been forced to write off the cost of common injectables or, at best, to estimate them. Yet it is clear that few hospitals can afford to give away medication or to rely on estimates, which are often unacceptable by the prepaid plans.

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The need to charge accurately and as completely as possible is being met by the TUBEX system in more and more hospitals across the nation. Typical of the accolades the system has won is the following, excerpted from *The Bulletin of the Parenteral Drug Association:*

The charge made to the patient should include all services rendered. When most of these services are built into the product by the supplier—guaranteed identified contents and dosage, guaranteed sterility, plus simplified record keeping and control—and included in a single purchase price paid to the supplier, there is no problem in justifying the charge to the patient. It is a charge that can easily be backed up by records, and it does not strain the credulity of any investigator.—Crohn, L.B.: The Bulletin of the Parenteral Drug Association, p. 23, March-April, 1960.

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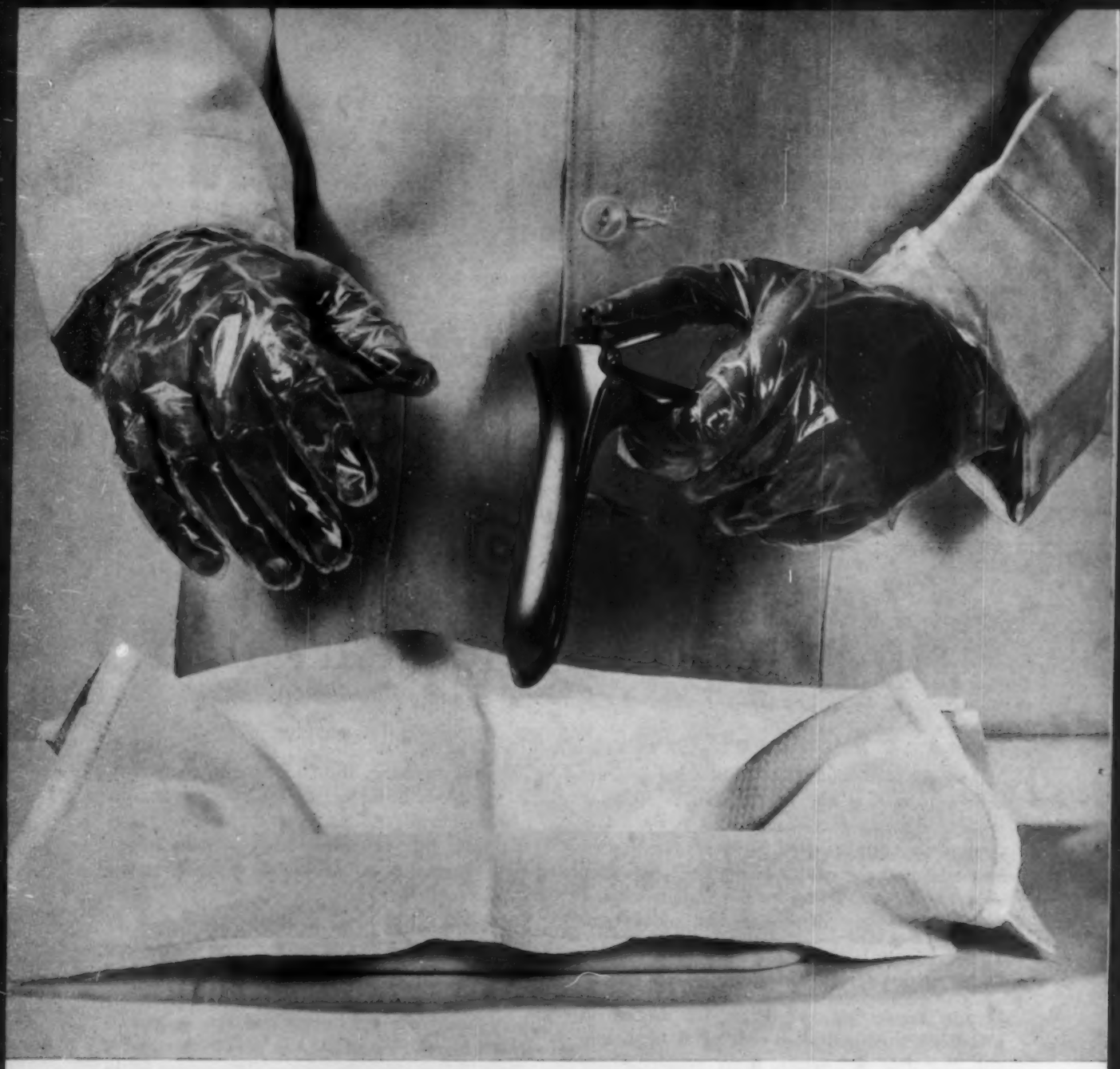

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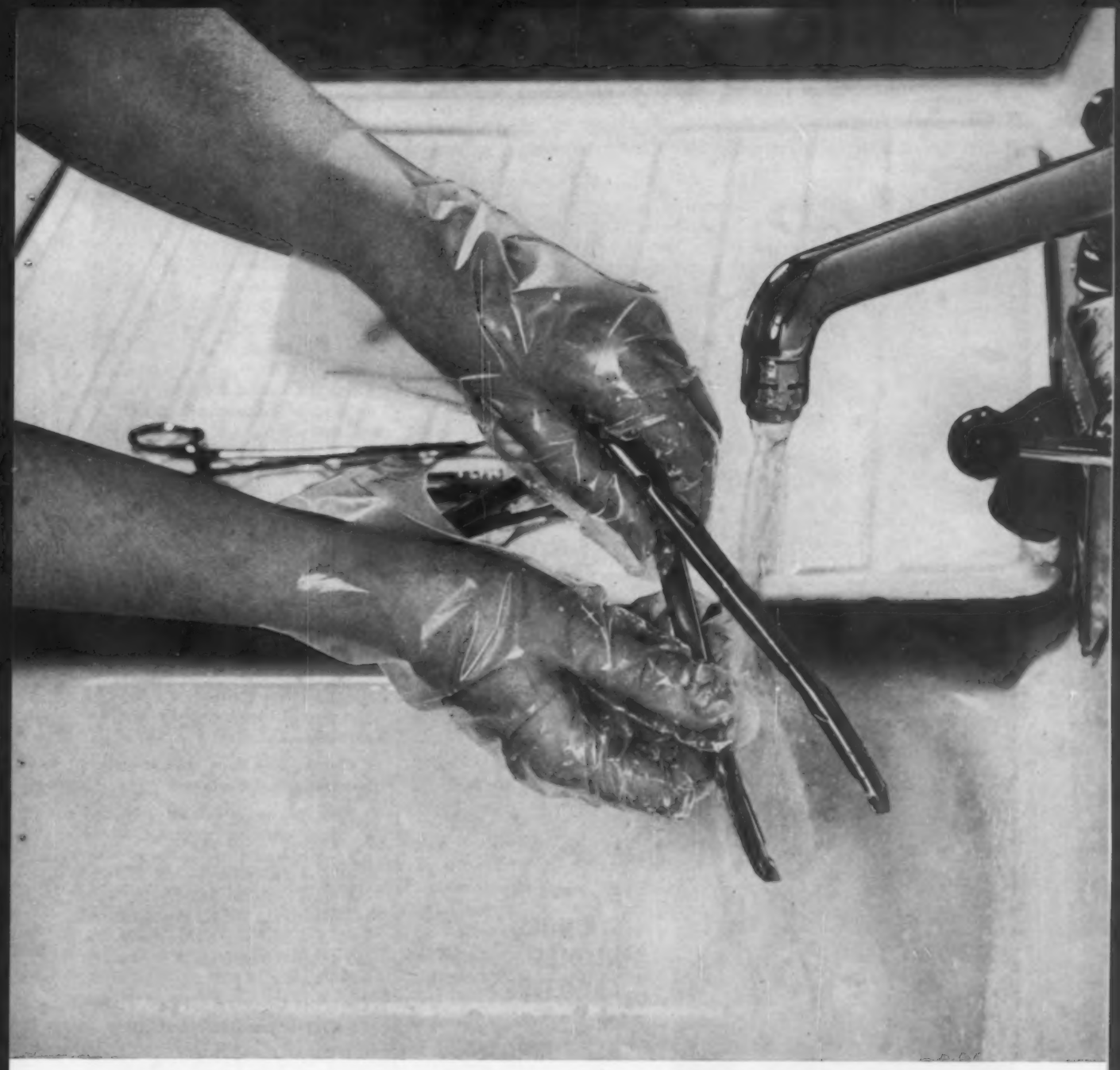

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Quebec Hospitals Are Asked To Help Draft Their Own Legislation by Prime Minister

MONTREAL, QUE. — Hospitals here were asked to help draft legislation governing their administration and operation by Jean Lesage, prime minister of the province.

Premier Lesage invited their participation in a speech presented at the Quebec Hospital Association's 1961 meeting.

"It is my profound conviction," he said, "that adoption of a hospital act in the province of Quebec would be a magnificent measure capable of bringing order to a domain which calls for immediate action."

The prime minister made it plain that the government did not want to infringe upon the autonomy of hospitals and medical associations, but he left little doubt that regulating legislation will be forthcoming. "The best hospital law," he pointed out, "will be one which you hospital people inspire."

At present, Quebec is the only Canadian province without binding legislation for virtually all parts of hospital operations.

One reason for the threat of increased government control, according to Dr. Jules Gilbert, is abuses by hospital administrators of the Quebec Hospital Insurance Plan. Dr. Gilbert, head of the Quebec Hospital Insurance Commission, warned his audience that "abuse leads inevitably to controls." The commission, he admitted, "is not entirely satisfied with the hospital insurance plan. There are still many kinks in it, due to the fact that it was drawn up in haste, on a small budget, and with restricted personnel."

Turning the problem around to its hospital side, Dr. J. Gilbert Turner said that one of the big troubles now perplexing hospitals is the huge debt with which they are saddled and for which the government has made no provision.

Dr. Turner is executive director, Royal Victoria Hospital, and the new president of the Quebec Hospital Association.

For the first time, the convention included a trustee program.

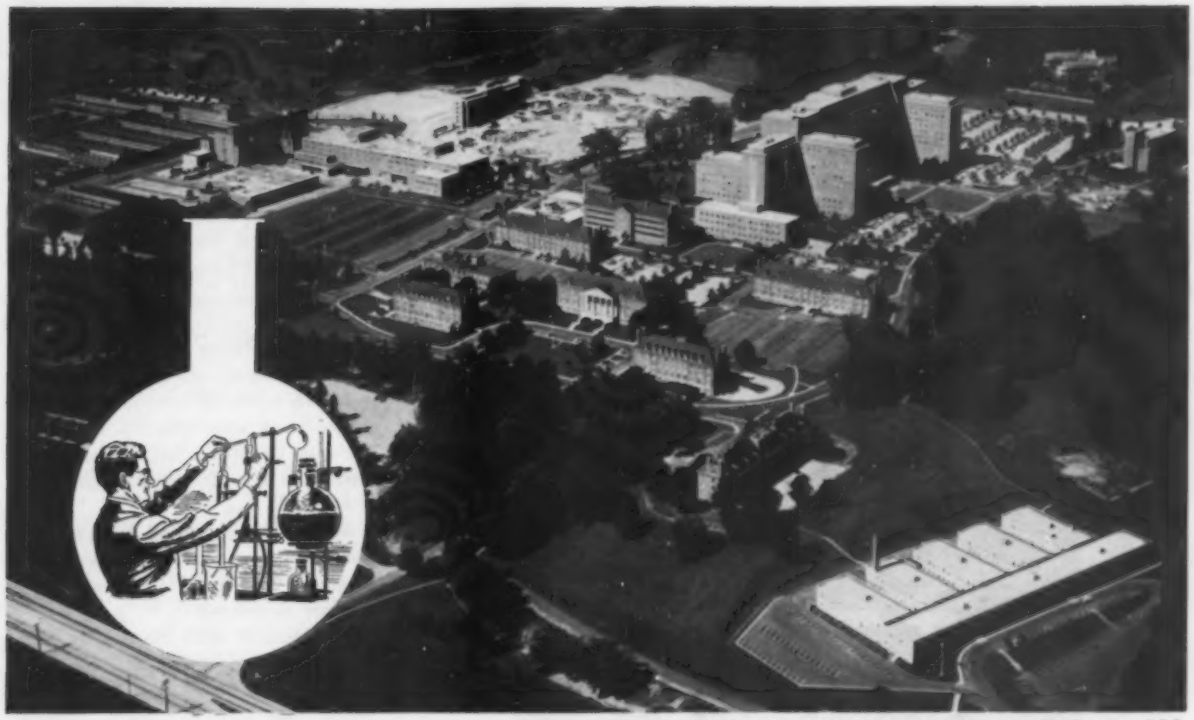
This featured a talk by Raymond P. Sloan, associate professor, school of public health and administrative medicine, Columbia University, and chairman, editorial board, The Modern Hospital. Mr. Sloan emphasized and explained the trustee's responsibility to the hospital and community.

Detroit Council Gives Vote to Osteopathic Hospitals

DETROIT. — Osteopathic hospitals were granted full membership in the Greater Detroit Area Hospital Council by unanimous action at its annual meeting here recently.

The amendment to the council's bylaws provides for full voting rights and full dues for the osteopathic hospitals, which previously had been admitted only as nonvoting members with half dues. (For other changes affecting osteopathy, see News Digest p. 132 and June, p. 138.)

William A. Mayberry, chairman of the Manufacturers National Bank, was elected president to succeed Allen W. Merrell. Mr. Merrell was elected to the newly created position of chairman of the board.



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Middle Atlantic Assembly Told Benefits of Planning by Regional Association

ATLANTIC CITY. — Efforts in community planning have resulted in three important benefits, the chairman of a regional hospital planning association reported at the Middle Atlantic Hospital Assembly here.

Chairman Clifford F. Hood of the Hospital Planning Association of Allegheny County, Pittsburgh, said such efforts "have educated the entire public to the importance of goals in health services, have promoted acceptance of standards by which to evaluate programs, and have established priorities for an effective plan of action."

Mr. Hood presented a history of the development of the planning association and listed its three major services as follows:

1. Research with respect to community needs, growth and character of the population, travel patterns of outpatients and inpatients, medical staff relationships and practices, and the utilization of beds and facilities.

2. Advisory service to the trustees, administrators and medical staffs of individual hospitals in their development of long-range plans.

3. Progress toward a comprehensive, flexible long-range plan of health services for Allegheny County, built upon the cooperation and long-range plans of the individual hospitals.

During the meeting the following Assembly officers were elected:

President, Carlton B. Shannon, administrator, House of the Good Samaritan, Watertown, N.Y.; vice president, Mabel A. Barron, administrator, Ellwood City Hospital, Ellwood City, Pa.; treasurer, John F. Worman, executive director, Hospital Association of Pennsylvania, Harrisburg, and secretary, J. Harold Johnston, executive director, New Jersey Hospital Association, Trenton, N.J.

New officers of the New Jersey Hospital Association were also named during the Assembly. They are:

President-elect, Nelson O. Lindley, administrator, Somerset Hospital, Somerville; president, Benjamin W. Wright, president and administrator, Hospital Center, Orange; vice president, Warren G. Rainier, director, Mountainside Hospital, Montclair, and treasurer, William H. Morrison, administrator, West Jersey Hospital, Camden.

Cleveland Hospitals Sue County Over Payments for Medically Indigent

CLEVELAND. — How poor is poor? This is, in effect, what hospitals here are asking in a suit against Cuyahoga County.

The 22 hospitals in the Cleveland area that brought the suit want the court to set aside local restrictions curtailing the use of relief funds to pay hospitals for the care of low income patients who cannot pay their bills.

They also ask that the county be ordered to pay in excess of $578,623 to cover part of the cost of care that the hospitals gave 1629 indigent inpatients between Jan. 1, 1960, and May 15, 1961, the *Cleveland Plain Dealer* reported.

Since January the county commissioners have ruled that Cuyahoga County will not give poor relief to any but those whose incomes are at least 20 per cent lower than the standard set by the state as a minimum for health and decency, thus disqualifying about 5000 persons this year, according to Thomas D. Griffiths, executive secretary of the Cleveland Hospital Council.

If the court holds with the hospitals, nearly $1 million a year in additional relief funds will be required, the *Cleveland Press* estimated.

Exhibitors Honored for C.H.A. Booths

DETROIT. — Awards for the best single and multiple exhibits were presented by the Hospital Industries Association at the close of the Wednesday morning general session of the Catholic Hospital Association.

Winners in the single booth category were:

First prize: Sterilon Corporation, Buffalo, N.Y.

Honorable mention: J. A. Deknatel & Son, Inc., Long Island, N.Y., and American Appraisal Company, Milwaukee.

Winners in the mutiple booth group were:

First prize: Excel Metal Cabinet Company, Inc., Jamestown, N.Y.

Honorable mention: Simmons Company — Hausted Division, Medina, Ohio, and Carrier Air Conditioning Company, Syracuse, N.Y.

COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Drake Hotel, Chicago, Oct. 25-28.

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Annual Institute, Indiana Univ., Bloomington, July 16-21.

AMERICAN ASSOCIATION OF HOSPITAL CONSULTANTS, Shelburne Hotel, Atlantic City, Sept. 23.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Benjamin Franklin Hotel, Philadelphia, Oct. 9-12.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convocation, Convention Hall, Atlantic City, Sept. 24.

AMERICAN COLLEGE OF SURGEONS, Conrad Hilton Hotel, Chicago, Oct. 2-6.

AMERICAN DENTAL ASSOCIATION, Sheraton Hotel and Convention Hall, Philadelphia, Oct. 16-19.

AMERICAN DIETETIC ASSOCIATION, Sheraton-Jefferson Hotel and Kiel Auditorium, St. Louis, Oct. 24-27.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN NURSING HOME ASSOCIATION, Pick-Carter Hotel, Cleveland, Oct. 2-6.

AMERICAN PUBLIC HEALTH ASSOCIATION, Cobo Hall, Detroit, Nov. 13-17.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC., Statler-Hilton Hotel, Los Angeles, Oct. 22-27.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Olympic Hotel, Seattle, Sept. 29-Oct. 8.

ARIZONA HOSPITAL ASSOCIATION, Ramada Inn, Phoenix, Oct. 19, 20.

ASSOCIATED HOSPITALS OF ALBERTA, Hotel Palliser, Calgary, Oct. 10-12.

ASSOCIATION OF DELAWARE HOSPITALS, Dover, Oct. 12.

BRITISH COLUMBIA HOSPITAL ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 17-19.

CALIFORNIA HOSPITAL ASSOCIATION, San Diego, Oct. 23-27.

COLLEGE OF AMERICAN PATHOLOGISTS, Seattle, Oct. 1-7.

COLORADO HOSPITAL ASSOCIATION, Boulder, Oct. 22-25.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Penn Harris Hotel, Harrisburg, Oct. 17, 18.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 10.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 16, 17.

ILLINOIS HOSPITAL ASSOCIATION, St. Nicholas Hotel, Springfield, Nov. 30, Dec. 1.

INDIANA HOSPITAL ASSOCIATION, French Lick Hotel, French Lick, Nov. 1-3.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 9, 10.

MARYLAND-D.C. HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, Nov. 8-10.

MINNESOTA HOSPITAL ASSOCIATION, Leamington Hotel, Minneapolis, Nov. 9, 10.

MISSOURI HOSPITAL ASSOCIATION, Sheraton-Jefferson Hotel, St. Louis, Oct. 11-13.

MONTANA HOSPITAL ASSOCIATION, East Glacier Hotel, East Glacier Park, Sept. 7, 8.

NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC., St. Paul Hotel, St. Paul, Oct. 2-6.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 12, 13.

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 2, 3.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 23-25.

OREGON ASSOCIATION OF HOSPITALS, Eugene Hotel, Eugene, Oct. 22-24.

RADIOLOGICAL SOCIETY OF NORTH AMERICA, Palmer House, Chicago, Nov. 26-Dec. 1.

(*Continued on Page 152*)

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SASKATCHEWAN HOSPITAL ASSOCIATION, Hotel Saskatchewan, Regina, Oct. 5, 6.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Sheraton-Cataract Hotel, Sioux Falls, Oct. 17, 18.

VERMONT HOSPITAL ASSOCIATION, Vermont Hotel, Burlington, Oct. 11, 12.

VIRGINIA HOSPITAL ASSOCIATION, John Marshall Hotel, Richmond, Nov. 9, 10.

WASHINGTON STATE HOSPITAL ASSOCIATION, Yakima, Oct. 26, 27.

WEST VIRGINIA HOSPITAL ASSOCIATION, Morgan Hotel, Morgantown, Oct. 19-21.

1962

AMERICAN HOSPITAL ASSOCIATION Midyear Meeting, A.H.A. Headquarters, Chicago, Jan. 31, Feb. 1.; annual meeting, Chicago, Sept. 17-20.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 23-25.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 25-27.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 23.

ABOUT PEOPLE

(*Continued From Page* 90)

Gladys Post, former assistant administrator at Indiana University Medical Center, Bloomington, has become administrator of Medical Environs, now under construction in University Heights, Ind. Miss Post has a master's degree in public health from Columbia University, a bachelor's degree from Ohio State University, and is a certified physical therapist.

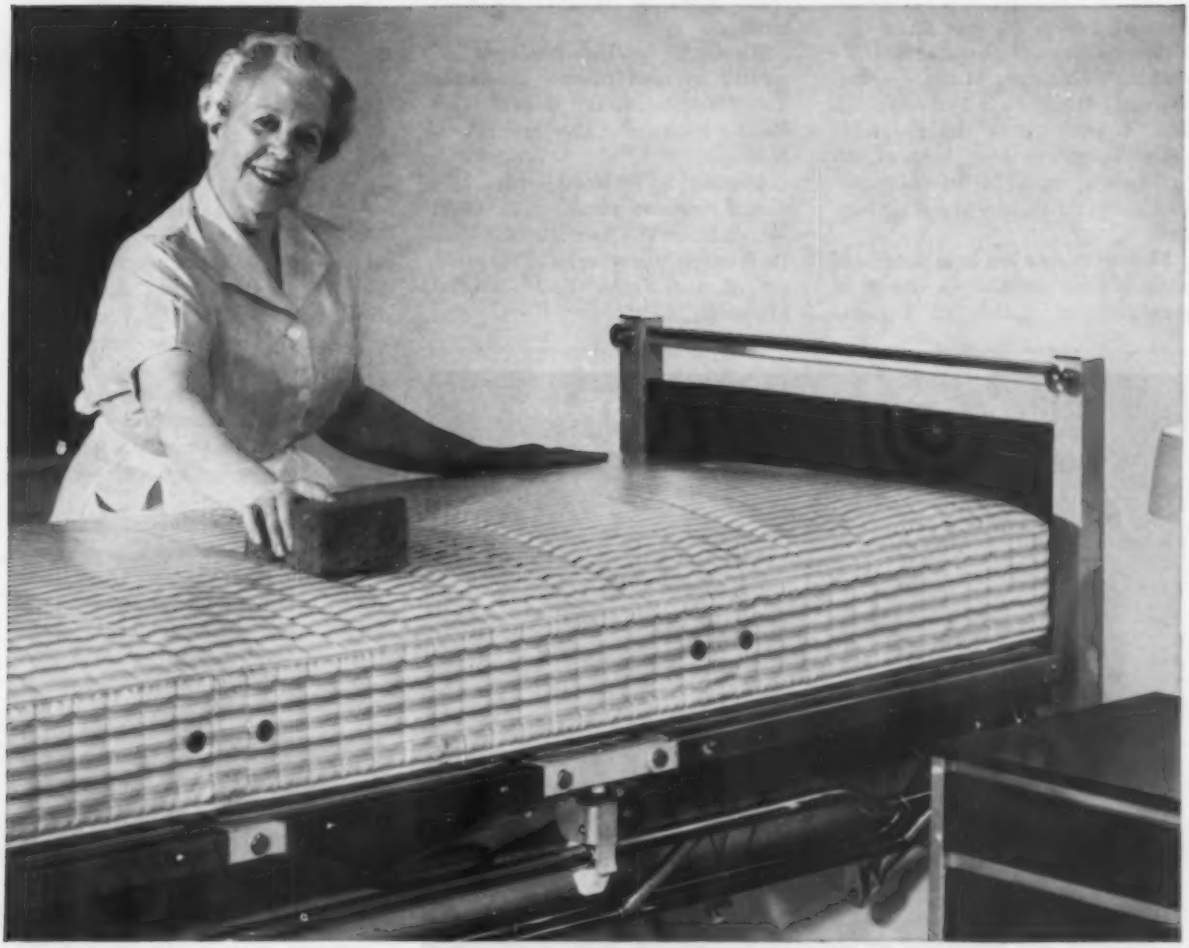
Gladys Post

Dr. George Abe is the new superintendent and medical director of Metropolitan State Hospital, Norwalk, Calif., succeeding **Dr. Robert E. Wyers,** who retired.

Irwin Albrecht, controller of Jewish Hospital of Saint Louis, has been promoted to assistant director and controller. At the same time it was announced that **James O. Hepner,** administrative assistant at Jewish Hospital, has been promoted to assistant director.

Edward J. Dailey Jr. has been appointed associate director of Muhlenberg Hospital, Plainfield, N.J. Mr.

What's REALLY NEW in hospital mattresses?



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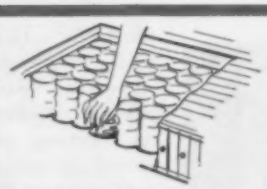

Beautyrest individually pocketed coils for finest patient care and comfort.

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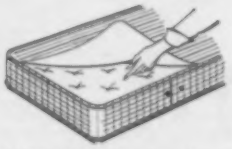

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Dailey is a graduate of Harvard University and served as assistant administrator of Massachusetts Memorial Hospital, Boston, for four years.

Henry Olshin has been named administrative assistant at the Knickerbocker Hospital, New York. Mr. Olshin, a graduate of the Columbia University program in hospital administration, served his administrative residency at Lebanon Hospital, New York.

Michael Diener has been appointed administrative assistant in charge of purchasing at Cedars of Lebanon Hospital, Los Angeles. Mr. Diener holds a master's degree in public health from the University of California.

Harold E. Josehart has been appointed assistant director of Butterworth Hospital, Grand Rapids, Mich. He is a graduate of the University of Michigan.

Charles S. Wisnoski has been named assistant administrator of St. Mary's Hospital, Grand Rapids, Mich. He formerly was administrative assistant of a U.S. Air Force hospital, Marysville, Calif.

Collin W. Griffiths has been appointed assistant administrator of Cape Cod Hospital, Hyannis, Mass. He was formerly administrator of Marshall Hospital, Placerville, Calif. Mr. Griffiths is a nominee of the American College of Hospital Administrators and a member of the Royal Society of Health.

Collin Griffiths

Roger G. Dvorak has recently become assistant hospital administrative services director at Philadelphia General Hospital, Philadelphia. He is a graduate of the University of Minnesota's course in hospital administration.

Dr. Thomas L. Nelson, superintendent and medical director of Sonoma State Hospital, Elridge, Calif., will resign in November. He has accepted an associate professorship in pediatrics at the University of Kentucky.

Wayne H. Herhold has been appointed associate director of Rockford Memorial Hospital, Rockford, Ill. He formerly was assistant director of William Beaumont Hospital, Royal Oak, Mich. Mr. Herhold has a master's degree in hospital administration from the University of Michigan.

Wayne Herhold

Kenneth T. Swanson is the new assistant administrator of Hackley Hospital, Muskegon, Mich. He holds a master's degree in hospital administration from the University of Minnesota.

Marshall C. Petring has been named assistant administrator of Shadyside Hospital, Pittsburgh, succeeding **Maurice P. Coffee.** Mr. Petring received his bachelor's degree from the University of Colorado and his master's degree in hospital administration from the University of Chicago.

Marshall Petring

Sam K. Johnson, former administrator of Henderson County Memorial Hospital, Athens, Tex., has been ap-

pointed purchasing agent of Harris Hospital, Fort Worth, Tex.

Department Heads

Marjorie S. Dodge, R.N., has been appointed assistant director of nursing service at White Memorial Hospital, Los Angeles.

Sarah Wade Hitchcock has been named director of nursing at Rex Hospital, Raleigh, N.C. She has been assistant director of nursing there for the last 10 years. **Bertha H. Boettner** has been appointed to the assistant directorship.

James E. Sheppard has been named controller of Baptist Memorial Hospital, Jacksonville, Fla. Mr. Sheppard was the 1960 president of the Northeast Florida Hospital Accountants Association. He was formerly controller of Riverside Hospital of Jacksonville.

James Sheppard

Edward S. Burroughs, former controller of Morton F. Plant Hospital, Clearwater, Fla., has been appointed controller of the American Legion Hospital for Crippled Children, St. Petersburg, Fla. **John R. Gray** has succeeded Mr. Burroughs at Morton F. Plant Hospital. Mr. Gray was previously controller for Braddock General Hospital, Braddock, Pa.

Maurice Cook has been named controller at Bethany Hospital, Kansas City, Kan.

Glanding Hadley, former controller of Lutheran Medical Center, Brooklyn, N.Y., has been appointed controller at Morristown Memorial Hospital, Morristown, N.J. He succeeds **Walter Kehoe,** who is the new controller of St. Luke's Hospital, Bethlehem, Pa.

James F. Hull has been named business manager of Hermann Hospital, Houston.

Vera M. Burke has been appointed director of social services for Bexar County Hospital District, San Antonio, Tex.

Paul H. Keller is the new director of personnel at Providence Hospital, Portland, Ore.

Henry A. Kallio has been appointed personnel officer for Western State Hospital, Fort Steilacoom, Wash. He formerly was administrator of Lompoc Community Hospital, Lompoc, Calif.

Miscellaneous

LeRoy E. Burney, M.D., former U.S. Surgeon General, U.S. Public Health Service, has been appointed vice president for health sciences, Temple University.

Duane E. Minard was named president of Hospital Service Plan of New Jersey (Blue Cross). He succeeds the late **Carl K. Withers.**

Dr. Richard L. Bohannon, head air force surgeon with the Pacific air forces for the last three years, has become deputy surgeon general of the U.S. Air Force.

Edith Drobisevskis has been appointed administrative assistant in charge of educational activities for the Cleveland Hospital Council. Miss Drobisevskis is a graduate of Baldwin-Wallace College, Berea, Ohio, and studied hospital administration at the University of Pittsburgh.

Edmund J. Shea, administrator of Indiana University Medical Center, has been appointed a consultant to the surgeon general of the U.S. Public Health Service. Mr. Shea is a past president of the Indiana Hospital Association.

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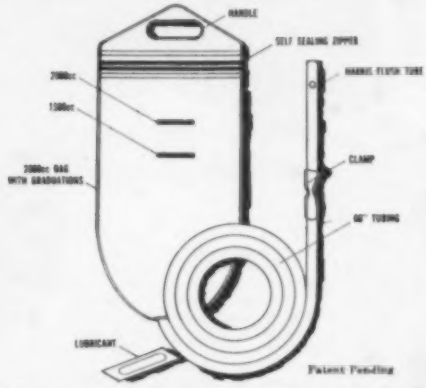

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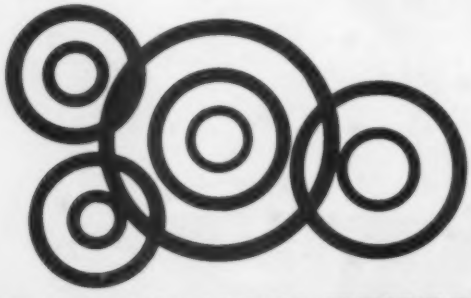

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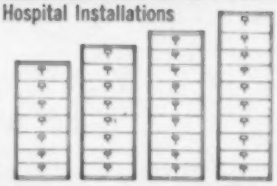

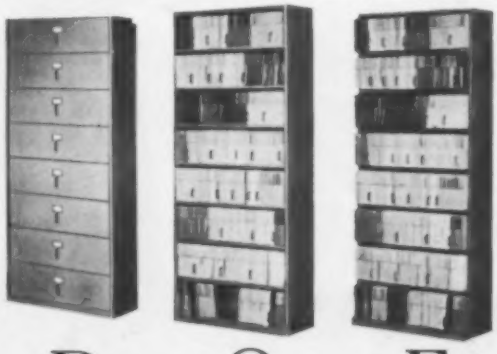

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ANESTHETISTS—Two certified registered nurses; female; experienced in all types and modern techniques of anesthesia desire positions in small community hospital located west of the Mississippi; references. Reply to MW 103, The MODERN HOSPITAL.

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ADMINISTRATOR—Age: 32 years; M.H.A. Degree, midwestern university, 1957; administrative assistant, 2 years; 2 years administrator, 250-bed midwestern hospital.

ADMINISTRATIVE ASSISTANT—Degree, Hospital Administration; 1 year executive assistant, 200-bed New York hospital; now completing residency.

BUSINESS MANAGER—Age: 33 years; Degree in Business Administration; 2 years hospital office experience; any location considered.

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PERSONNEL MANAGER—Degree, Creighton University; 4 years experience, director of personnel & public relations; prefers west; southwest.

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ANESTHETIST—Nurse; to join anesthesiologist and nurses. Write to MO 341, The MODERN HOSPITAL.

ANESTHETIST—Opening for 2nd anesthetist in general hospital of 62-beds; desirable position for one wishing light work schedule; salary open; usual fringe benefits. CARMI TOWNSHIP HOSPITAL, Carmi, Illinois.

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ANESTHETIST—Nurse; for 604-bed general hospital, no pediatric department, 40 hour week, plus overtime, salary open, generous employee benefits. Apply Personnel Office, AKRON CITY HOSPITAL, 525 East Market Street, Akron 9, Ohio.

ANESTHETIST—Nurse; $500; new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETISTS—Immediate openings in a chain of ten general hospitals located in the coal mining communities of eastern Kentucky, southwestern Virginia, and southern West Virginia; salary at the rate of $5,880 per annum, annual increments, 4 weeks paid vacation, 7 paid holidays, sick leave, non-contributory retirement plan plus social security. Write to MINERS MEMORIAL HOSPITAL ASSOCIATION, Box 61, Williamson, West Virginia.

ANESTHETIST—Nurse; C.R.N.A. to work with anesthesiologist in 100-bed hospital; collegetown; liberal employment policies; salary open. Contact L. E. Wells, M.D., SOUTHSIDE COMMUNITY HOSPITAL, Farmville, Virginia.

DIETITIAN—Opening available immediately; midwest college town, 75-bed hospital with 60-bed expansion in near future; salary open. Apply MO 345, THE MODERN HOSPITAL.

DIETITIAN—Must have hospital experience and be qualified to take complete charge of this southern California hospital of 75-beds in the Pasadena area on a full-time basis; salary open. Reply R. M. Mershon, Personnel Director, P. O. Box 74, Temple City, California.

DIETITIAN—An opportunity for the qualified dietitian to make full use of her abilities in an interesting and rewarding position; ADA registration or comparable experience required; fully accredited, 250-bed, teaching, non-sectarian, community hospital; $2,000,000 development program underway, which will provide completely new dietary department, additional bed capacity, plus many other modern facilities. Apply Personnel Director, RAVENSWOOD HOSPITAL, 1931 W. Wilson, Chicago 40, Illinois.

DIETITIAN—Excellent opportunity for ADA registered dietitian planning modified diets, writing modified menus, selecting and training employees and directing work of dietary supervisors; 500-bed hospital with 180 dietary employees; salary commensurate with training and experience; liberal benefits. Reply Personnel Director, IOWA METHODIST HOSPITAL, Des Moines 14, Iowa.

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries beginning at $350.00 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians allowed overtime work and are paid at an hourly rate based on monthly salaries; three weeks vacation; social security; Blue Cross. Apply Director of Dietetics, BARNES HOSPITAL, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Preferably registered, or at least well qualified to handle 272-bed general hospital; salary at least $25.00-$30.00 per day with room and board; beautiful nurses' home with all private rooms nicely furnished; responsible for preparing menus and special diets and supervising personnel in entire department; purchasing is done through full-time purchasing agent. Write giving full qualifications to DOVER GENERAL HOSPITAL, Jardine Street, Dover, New Jersey, c/o C. T. Barker, Director.

DIETITIAN—Therapeutic; salary range over $5,000.00; 3 weeks paid vacation; possible advancement to assistant director of department soon; fully accredited 503-bed general hospital (teaching center—300 students.) Apply Director of Dietetics, AULTMAN HOSPITAL, Canton 10, Ohio.

DIETITIAN—Chief; A.D.A.; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open, 4 weeks vacation; social security; Blue Cross and Blue Shield available. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIANS—Female; (a) for therapeutic; (b) for main kitchen food production; must be A.D.A. and prefer experienced; 300-bed hospital, adjacent to University of Pittsburgh; housing facilities available, excellent personnel policies; salary open. Write MONTEFIORE HOSPITAL, 3459 Fifth Avenue, Pittsburgh 13, Pennsylvania.

DIETITIANS—Positions open in two of the larger hospitals within a network of ten general hospitals operating in the Appalachian coal mining region of Kentucky, Virginia, and West Virginia; ADA membership required, with experience in administration, teaching, and/or therapeutics; 40 hour week, 4 weeks paid vacation, 7 paid holidays; employee health program; social security, plus non-contributory retirement plan; salary open. Write or call collect: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, Williamson, West Virginia. Phone: BElmont 5-2424, Ext. 24.

DIRECTOR HOSPITAL FOOD SERVICE—Excellent opportunity in 600-bed hospital with A.D.A. internship, recently completed addition with the most modern cafeteria and

(Continued on page 162)

classified advertising

POSITIONS OPEN

food service; approved school of nursing, resident-intern program; generous benefit program with progressive personnel policies. Apply Personnel Director, THE CHRIST HOSPITAL, Cincinnati 19, Ohio.

DIRECTOR OF NURSING—For a 180-bed hospital located in southern New England; must have Masters Degree and be capable of directing nursing school and service; salary $8,000 up, dependent upon experience; excellent fringe benefits; willing to consider persons with limited experience who have potential; please provide full details in first letter. Write to Box MO 338, The MODERN HOSPITAL.

DIRECTOR OF NURSING—Modern JCAH approved 100-bed general hospital; no school of nursing; beautiful southern Vermont community, 3 hours drive from Boston; private apartment available; salary commensurate with qualifications; willing to consider experienced assistant director desirous of promotion to director; excellent fringe benefits, superior security. Apply MO 346, The MODERN HOSPITAL.

DIRECTOR OF NURSING EDUCATION—For immediate placement in a hospital affiliated school of nursing accommodating 90 students located 4 blocks from the campus of the University of Illinois and 2 hours by train from Chicago; school is fully staffed with on-going program; hospital fully accredited by the JCAH; starting salary $7200 plus benefits; applicants must have a masters in nursing education. Write The Administrator, BURNHAM CITY HOSPITAL, Champaign, Illinois.

DIRECTOR OF NURSING—Director school and service 300-bed hospital; minimum of BA required; $700-$800 per month plus life insurance, sick leave and accident policy, vacation and holidays; apartment available. Apply Administrator, THE OHIO VALLEY HOSPITAL, Ross Park, Steubenville, Ohio.

DIRECTOR, PHARMACEUTICAL SERVICES—Qualified by training and/or experience to assume responsibilities for pharmacy, central sterile supply, and teaching to school of nursing and professional staffs; eligible for Ohio registration; large general teaching hospital with formal medical school and research programs. Apply Assistant Director of Personnel Relations, CLEVELAND METROPOLITAN GENERAL HOSPITAL, 3395 Scranton Road, Cleveland 9, Ohio.

DIRECTOR—Social service; female; in very active, fully approved, general hospital—247-bed capacity; currently expanding to 310-beds; located in the Hudson River Valley; pleasant working conditions, liberal personnel policies; state minimum salary requirement Write to MO 340, The MODERN HOSPITAL.

EXECUTIVE DIRECTOR—For new non-profit retirement residence about to be built by Plymouth Residence, Inc., an affiliate of PLYMOUTH CONGREGATIONAL CHURCH, 19th & Nicollet, Minneapolis, Minnesota. Write for job description and further information.

(Continued on page 164)

classified advertising

POSITIONS OPEN

EXECUTIVE DIRECTOR—Royal Alexandra Hospital, Edmonton, Alberta; 729-bed general hospital now adding 600 more beds; large new school for nurses; medical undergraduate teaching; either medical or non-medical background acceptable; experience needed; state qualifications, salary expected and when available; please furnish references. Apply B. C. Whittaker, Q.C., Chairman, EDMONTON HOSPITAL BOARD, Room 304 Canadian Bank of Commerce Building, Edmonton, Alberta.

HOUSEKEEPER—Executive; $530 to $644 monthly; requires college graduation, two year's administrative housekeeping experience; or high school graduation, four years administrative experience; direct staff of 100 in large teaching hospital; all civil service benefits. Apply to ALAMEDA COUNTY CIVIL SERVICE, 188 12th Street, Oakland 7, California.

HOUSEKEEPER—Executive: A very desirable position available immediately for an experienced housekeeper to carry on a well organized training program and direct our large housekeeping staff; we are a 450-bed general hospital with complete modern facilities; you will receive many employee benefits including an excellent retirement program. Please mail your professional qualifications to the Personnel Director, BUTTERWORTH HOSPITAL, Grand Rapids 3, Michigan.

INSTRUCTOR—Fundamentals of nursing; B.S. degree and teaching experience required; includes both formal and clinical instruction; Diploma Program; remuneration and fringe benefits excellent. Apply The WILLIAM W. BACKUS HOSPITAL, Personnel Department, Norwich, Connecticut.

INSTRUCTOR—In nursing care of children; diploma school; 300-bed hospital close to Baltimore and Washington; Bachelors degree preferred. Apply Director of Nursing, WASHINGTON COUNTY HOSPITAL, HAGERSTOWN, Maryland.

INSTRUCTOR—Medical & surgical; Degree in Nursing or Nursing Education, 150-bed hospital, modern; Central Pennsylvania; $4800 to start; send background information. CLEARFIELD HOSPITAL, Turnpike Avenue, Clearfield, Pennsylvania.

INSTRUCTOR—Clinical; medical-surgical nursing; Diploma school of nursing in 500-bed hospital, with 150 students; B.S. degree required; position available immediately; salary commensurate with experience, regular increments to maximum for educational level. Apply Director of Nursing, LANCASTER GENERAL HOSPITAL, Lancaster, Pennsylvania.

LIBRARIAN—Registered medical records; challenging opportunity for a fully qualified medical records librarian to take over an active record department presently undergoing complete remodeling and reorganization; salary open, fully accredited 250-bed teaching, non-sectarian community hospital; approved intern resident program and schools of nursing, anesthesia and X-ray technology; $2,000,000 development program underway to provide new surgical suite, intensive care unit, psychiatric section and additional bed capacity. Apply, Personnel Director, RAVENSWOOD HOSPITAL, 1931 Wilson Avenue, Chicago 40, Illinois.

(Continued on page 166)

Multi-Clean Floor and Scrubbing Machines are used for waxing, polishing, buffing, and scrubbing.

Quiet Multi-Clean Vacs pick up scrub water, remove dust, reduce spread of airborne bacteria.

Effective Multi-Clean antiseptic cleaners are ideal for cleaning floors, walls, bathroom fixtures.

These cleaners are recommended for surgery, too. They leave no film to affect conductivity of floors.

Bowl Cleaner quickly dissolves scale from lavatories, toilet bowls, other acid-resistant fixtures.

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DESTROYS STAPHYLOCOCCUS. MULTI-CLEAN *Staph-trole* is powerful wide spectrum antiseptic cleaner. Destroys many types of bacteria including *Staphylococcus Aureus* at dilutions as great as 200:1. Detergent's penetrating action increases germicidal effectiveness. Leaves no film.

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REDUCES SPREAD OF AIRBORNE BACTERIA. *Super Floor Dressing* contains Germicide HR7 which destroys most bacteria on contact, greatly reducing their spread by air. Stops mophead odors by preventing bacteria growth in mop. Cleans, polishes, improves anti-slip properties, reduces rubber marking, extends life of wax.

FAST-ACTING BOWL CLEANER. MULTI-CLEAN *PBM Bowl Cleaner* is a light-bodied liquid for removing scale and other deposits from acid-resisting fixtures such as toilet bowls, lavatories, and urinals. Has practically no odor of its own and contains a chemical which helps control odors.

COMPLETE LINE OF WAXES, SEALERS and CLEANERS. MULTI-CLEAN manufactures more than 50 high quality materials for care and maintenance of all type floors. These include light-colored resinous sealers and finishes, high-gloss anti-slip waterproof waxes, and a wide variety of hospital cleaners.

FLOOR MACHINES, SCRUBBING MACHINES and **WET PICKUP VACUUM CLEANERS.** This efficient, quiet-running cleaning equipment lets housekeeping staff save valuable time while keeping floors and walls bright, clean, sanitary. Scrubbing Machine solution tank holds 3½ gallons of antiseptic cleaner.

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POSITIONS OPEN

LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week, salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

LIBRARIANS—Registered medical record; Positions in three of ten general hospitals located in eastern Kentucky, southwestern Virginia, and southern West Virginia, operating on a regional pattern; two positions can be filled by a recent graduate, other position requires 3 years experience for consultative duty to community hospitals in region; salary $4,860 and $5,340 per annum; 40 hour week, 7 paid holidays, 4 weeks vacation, social security, employee health and increment program. Write: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, Williamson, West Virginia.

MISCELLANEOUS—THOMAS D. DEE MEMORIAL HOSPITAL, Odgen, Utah, 238-beds, 7 specialty departments, located in Utah's most progressive city and in the heart of the scenic west; openings available for Pharmacist, Registered Medical Technologists, X-ray technicians, and several assignments for Registered Nurses; attractive policies, liberal benefits and an exceptionally fine professional environment. Write or wire Director of Personnel.

(LOOKING FOR ADVANCEMENT IN THE NURSING FIELD—SEE PAGE 27)

NURSES—Registered; for general staff and operating room; 202-bed JCAH accredited general hospital; many inviting fringe benefits; to complement present excellent staff situated 19 miles west of Sacramento, 85 miles north of San Francisco, 10 miles from University of California at Davis. Apply Herbert Bauer, M.D., Medical Director, YOLO GENERAL HOSPITAL, Woodland, California.

NURSES—General duty; for 320-bed JCAH accredited general hospital, only a few blocks from Lake Michigan beach and Lincoln Park; near Chicago Loop; school of nursing accredited by NLN; apartments available close to hospital; liberal personnel policies; openings on all shifts; must be eligible for Illinois registration. Write Director of Nursing, AUGUSTANA HOSPITAL, 411 W. Dickens Avenue, Chicago 14, Illinois.

NURSES—Staff; 455-bed, fully accredited general hospital adjacent to college campus; 40 hour week, 2 weeks vacation, $340 month for 3-11 & 11-7. Apply Director Nursing Service, BALL MEMORIAL HOSPITAL, Muncie, Indiana.

NURSES—General duty; R.N.; salary $3744 to $4680; good health, satisfactory references prerequisites; excellent working conditions and benefits. Apply Personnel, PINELAND HOSPITAL AND TRAINING CENTER Pownal, Maine.

NURSES—Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

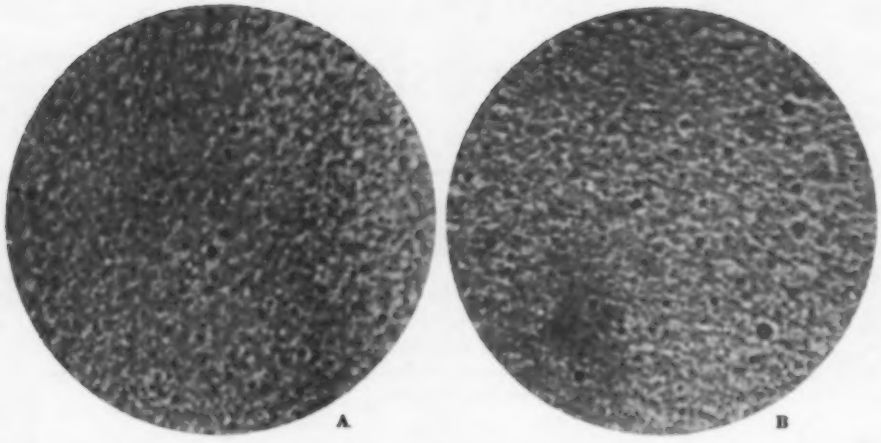
PHARMACIST—Must have the following qualifications: graduate of an approved school of pharmacy and possession of a license as a registered pharmacist as issued by the Pennsylvania State Board of Pharmacy or eligible for such licensure; salary range $5529 to $7407 per annum; forty-hour work week; fringe benefits include 15 days paid vacation, 15 days paid sick leave, 13 paid legal holidays, regular meritorius increases; group insurance and retirement plans; qualified candidates write or call Personnel Director, WARREN STATE HOSPITAL, Warren, Pennsylvania, for interview.

SALESMEN—We are looking for sales representatives who have established contacts with hospitals to sell a specialty line of Industrial Service Lighting Products; exclusive territories available; high commission and repeat business assured. Write: INDUSTRIAL SERVICE CO., P. O. Box 51, Baltimore 3, Maryland.

SOCIAL WORKER—Medical; must have two years graduate training in social work; will assume full responsibility for program in TB sanitarium; salary $423 to $515; annual leave, sick leave, State retirement plan; Write State Capitol Building, Merit System, Phoenix, Arizona.

SUPERVISOR—Obstetric department; B.S. Degree in Nursing with experience in obstetrical nursing; deliveries average 100 monthly; salary commensurate with preparation and experience; personnel policies include one month vacation, retirement plan and group life insurance. Apply The WILLIAM W. BACKUS HOSPITAL, Personel Office, Norwich, Connecticut.

(Continued on page 168)



Which is chyle and which is Lipomul I.V.?†

As you know, after digestion, fat passes as an emulsion called chyle through the lacteals into the lymphatics tributary to the thoracic duct, and then into the systemic circulation. Lipomul I. V., like chyle, is a fine milk-white emulsion of fat. Its fat particles approximate those of chyle in size: about *1/7 the diameter of the normal red blood cell.* Because of this minute particle size, like chyle, Lipomul I. V. is *non-irritating to the vein.* The fat provides *8 times more calories* per cc. than does 5% glucose and with markedly increased protein-sparing action. It is *swiftly* and *completely metabolized.* Therefore, when formation of chyle, a major source of calories, is blocked during pre- and post-operative "digestive tract bypass," many surgeons add Lipomul I. V. to their standard fluid and electrolyte regimen to provide the most concentrated source of energy.

†A—Mammalian chyle (highly magnified)
B—Lipomul I. V. (highly magnified)

Formula:

Cottonseed oil	15% w/v
Dextrose anhydrous	4% w/v
Lecithin	1.2% w/v
Oxyethylene oxypropylene polymer	0.3% w/v
Water for injection	q.s.

Supplied in 250 cc. and 500 cc. bottles

Indications and effects

Lipomul I. V., fat emulsion for parenteral use, supplies approximately 400 calories per 250 cc. It is indicated in patients who are unable to take adequate food by mouth for any considerable period of time.

Administration and dosage

Administer only by intravenous route, as follows:

For adults

First 5 minutes	10 drops/minute
Next 25 minutes	40 drops/minute
Then	60 drops/minute

For infants and children

First 5 minutes	5 to 10 drops‡/minute
Next 25 minutes	0.5 to 1 drop per pound/minute
Then	0.5 to 1 drop per pound/minute

‡1 cc.—approximately 20 drops.

Precautions and side effects

To administer, use only the recipient set supplied in the package; Lipomul I. V. must not be mixed with transfusions, infusions, or any other parenteral medication, or be given simultaneously through the same tubing. A total of not more than 14 units (500 cc. each), at a rate not exceeding 2 units per day, should be given to any one patient.

Reactions of a "colloid" type may occur, including back or chest pain, dyspnea, severe flushing, or urticaria. There may be delayed chill. Transient fever has also been noted, as have such other minor reactions as nausea, vomiting, abdominal discomfort, headache, mild flushing, dizziness, and some variations in blood pressure and pulse.

When the recommended dosage is exceeded, an "overloading syndrome" may occur characterized by chill, fever, abdominal pain, nausea, vomiting, hepatomegaly, clotting defects, thrombocytopenia, and bleeding, particularly from the gastrointestinal tract.

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Trademark, Reg. U. S. Pat. Off.
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ASSOCIATE DIRECTOR—Nursing service; $8,000.

ADMINISTRATORS—(a) 200-bed hospital; Mass. (b) 65-bed N. J. hospital; expansion program. (c) 50-bed hospital, Pa. (d) 60-bed Ohio hospital. (e) R.N.; Small southern hospital.

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BUSINESS MANAGERS—(a) 200-bed hospital, Fla. (b) 400-bed hospital, suburb New York. (c) Credit-collection manager; 200-bed eastern hospital.

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ALL INQUIRIES FROM APPLICANTS ARE KEPT STRICTLY CONFIDENTIAL

(Continued on page 170)

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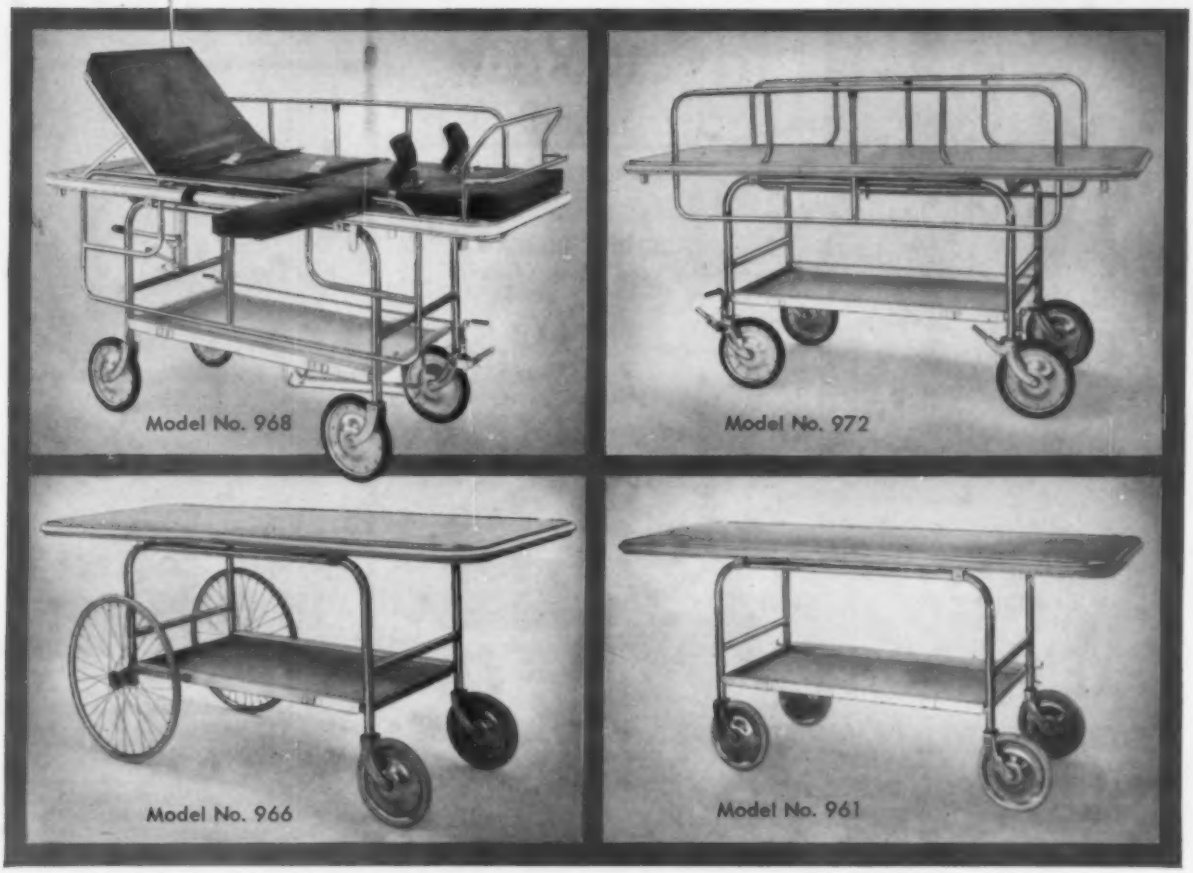

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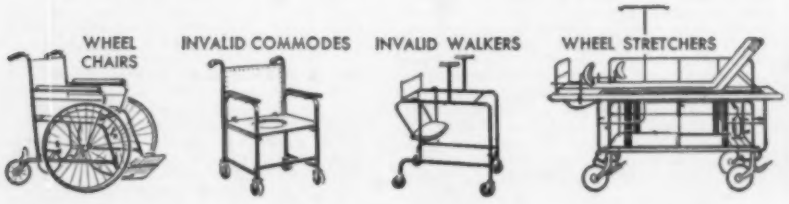
Yes, if it's a genuine Gendron, it's the finest of its kind, and at a cost to fit any hospital budget. This all-new Gendron wheel stretcher line has been designed and manufactured with the usual Gendron quality features with ruggedness, ease of handling and patient comfort foremost in mind.

Many features, including Gendron exclusives, such as 1¼ in. Steel Tubing throughout, are standard equipment. However, a complete line of accessories to assure proper patient care are available at a minimum additional cost. Write for Catalog #WS-61, or see your nearest Gendron supply dealer.

GENDRON . . . FOR OVER 85 YEARS THE QUALITY MANUFACTURER OF WHEELED EQUIPMENT FOR THE PATIENT OR THE HANDICAPPED



THE GENDRON WHEEL COMPANY
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For additional information, use postcard facing back cover.

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Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

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IDEAL FOOD CONVEYOR CART, Model #5020 T (hold 16 trays) in good condition. Price to be quoted upon inquiry. Write to BLESSING HOSPITAL, 1005 Broadway, Quincy, Illinois.

The "how-to-do-it" series of articles on housekeeping technics, reprinted from the Modern Hospital, is now available in book form. Valuable teaching aid for training housekeeping employes. Write Emily C. Deming, BUTTERWORTH HOSPITAL, Grand Rapids, Mich.

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 3841 Maryland Avenue, Chicago 37, Illinois.

ST. FRANCIS HOSPITAL School of Anesthesia offers to graduates of accredited schools of nursing, an 18 months course in anesthesia. AANA accredited; approved under G.I. Bill of Rights. Stipends offered throughout course. Classes begin April 1 and October 1, each year. Write Sister M. Catherine Ann, O.S.F., C.R.N.A., Director, School of Anesthesia, ST. FRANCIS HOSPITAL, Peoria 4, Ill.

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurses Anesthetists. Unlimited opportunities for endotracheal intubations, open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan."

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CHARLES T. MILLER HOSPITAL offers qualified graduate nurses a 16 weeks' course in operating room nursing. The course includes instruction and supervised experience in all surgical specialties as well as teaching and management techniques. Room, board, laundry, and a stipend of $125 per month are provided. For information address Director of Nursing, CHARLES T. MILLER HOSPITAL, St. Paul 2, Minn.

BARNES HOSPITAL—Offers an 18 month post-graduate course on Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Mo.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, PROVIDENCE LYING-IN HOSPITAL, Providence 8, Rhode Island.

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He drives a **Linde** delivery truck. And to you, this is important—it means he's backed by a leading manufacturer of Oxygen U.S.P....by the fastest, most flexible distribution network in the country.

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Dependable oxygen delivery is vital to a hospital. This is just one of the many services Linde is ready to offer you. To learn about the others, call your nearest Linde representative or distributor or write Linde Company, Division of Union Carbide Corporation, 270 Park Avenue, New York 17, N. Y. In Canada: Union Carbide Canada Limited, Linde Gases Division, Toronto 12.

Linde / first in Oxygen U.S.P.

LINDE COMPANY UNION CARBIDE

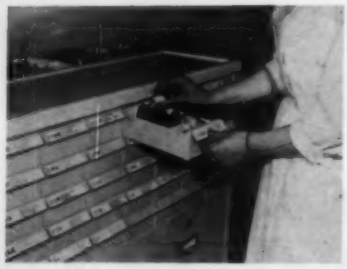
WHAT'S NEW

Edited by BESSIE COVERT

LOOK inside back cover for Postage Paid inquiry card for more information.

The Brewer System of Drug Control Saves Time, Money and Possibly Patients

The Brewer System of Drug Control offers the hospital a simplified, accurate method of handling and dispensing drugs. The possibility of administering incorrect medication is practically eliminated with the system, which facilitates the working partnership of pharmacy and nursing staffs, and removes the burden of accounting from these services. Appreciable savings in time are effected for all involved in drug handling, accurate records for pharmacy, nursing and accounting services are supplied, and the teaching of nurses and house staff is facilitated.



The constantly increasing number of new drugs, the use of multiple medications, and high occupancy rates aggravate the problem of control, which is largely solved by the system. It prevents the loss of drug inventory through theft and pilferage, borrowing, personal use, spillage and instability of drugs, even though drugs are available 24 hours a day, and the loss of revenue through drug charges not issued, lost, illegible, late or inaccurate.

Components of the System
include the Brewer Medication Box, Drug Station, Drug Cart, forms, supplies, procedures, and the Brewer System consultation program. When set up, it assures a continuing annual per-bed profit on pharmacy operations.

Brewer Consultants
To ensure full and efficient use of the Brewer System, consultants are hospital-trained in all phases of its operation, installation and servicing, and are available for installation, training of personnel and general consultation through **Brewer Pharmacal Engineering Corp., 9138 West Chester Pike, Upper Darby, Pa.**

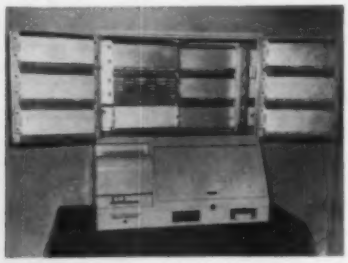
These are the components and procedures which assure accuracy and protect the drug supply

Procedure
When a patient is admitted, a duplicate identification plate, made on the same equipment that makes the original patient plate, is housed in a special drug plate holder in the Drug Station. Two Kardex files are maintained, one for recording treatments, nursing care and diets, and another for medications.

After the doctor has written his orders, the nurse prepares a form for the new patient which is inserted in the Kardex file. To obtain medication, the nurse takes the patient's identification plate to the drug station, places it on the proper shuttle, and uses her key to unlock the door and remove the desired drug plate. This is placed with the patient's plate, a snap-out form is inserted with a charge ticket, and the activator button is pressed.

The machine automatically delivers the requested medication and prints the data from the two plates on the label, the charge ticket and the locked-in recording tape. The nurse drops the charge ticket into a slot in the drug station, affixes the label to the package and places it in the patient's drawer.

The Brewer Drug Cart
is a self-contained medication cart which can be completely locked and contains an independently locked drawer for narcotics, which complies with government regulations. The front of the top is a convenient working surface, while receptacles are provided in the back portion for supplies. Small individual patient drawers contain the medication and charge plates.



The Drug Station
is an electronically controlled, self-contained, essentially burglarproof unit for the storage and issuing of the prepackaged drugs, located on the nursing floor and stocked by the pharmacist. It contains up to 96 different drugs, in units of eight Medication Boxes. Also stored in it are drug charge plates corresponding to the number and strengths of the drugs stored within the station, charge slips, and a register tape and mechanism which automatically and permanently records each drug transaction.

Drug Administration
For administration, the nurse wheels the Drug Cart to the patient's room, consults the routine medication form, opens the patient's individual drawer and gives the medication. In the case of injections, the nurse prepares the syringe at the bedside. After administration, the nurse initials the transaction in the alloted space. When all medications are completed, the locked Drug Cart is returned to the nursing station and the nurse is free for other duties.

For more details circle #701 on mailing card.

(Continued on page 175)

NURSES CALL SYSTEMS

Modular Design: Easy To Maintain

Combination phone and annunciator nurses station has satin finish stainless steel faceplate . . . rugged molded plastic construction . . . simple lift-off-the-phone answering . . . push button selection . . . override operation for emergency calls . . . flush, surface or desk mounting . . . these are some of the advanced features typical of the modern Nurses Call Systems offered by Couch . . . available in modular units so you can tailor a system to fit your individual requirements.

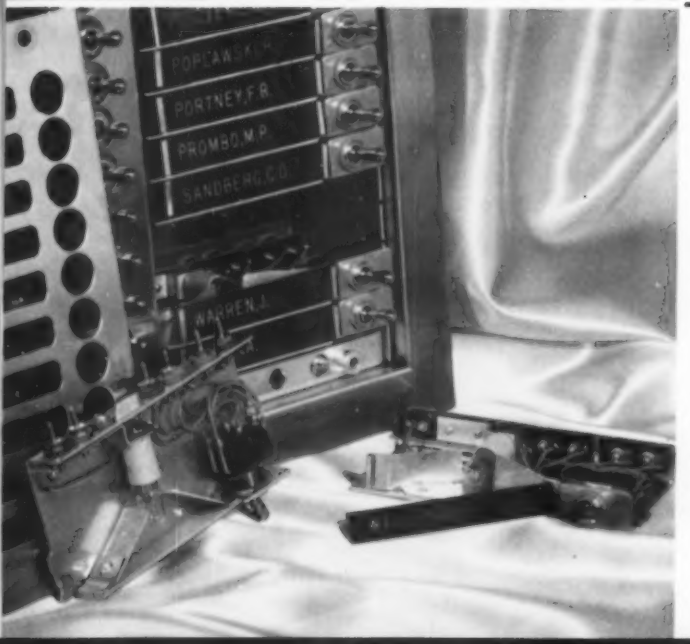
Nurses Station

LOCAL FIRE ALARM SYSTEMS

Modular Design: Great Flexibility

Fire alarm control panels are completely dead front . . . no possibility of electrical shock . . . plug-in relays completely enclosed . . . exceptionally compact cabinets . . . these are typical of the few standardized components . . . building block fashion to create a great variety of fire alarm systems . . . with approval of not only UL but the more restrictive federal, state and local codes . . . with provision for automatic fire detection and connection to city fire alarm system.

Fire Alarm
Control Panel



STAFF IN-OUT REGISTER SYSTEMS

Plug-in Units Give You A Wide Choice

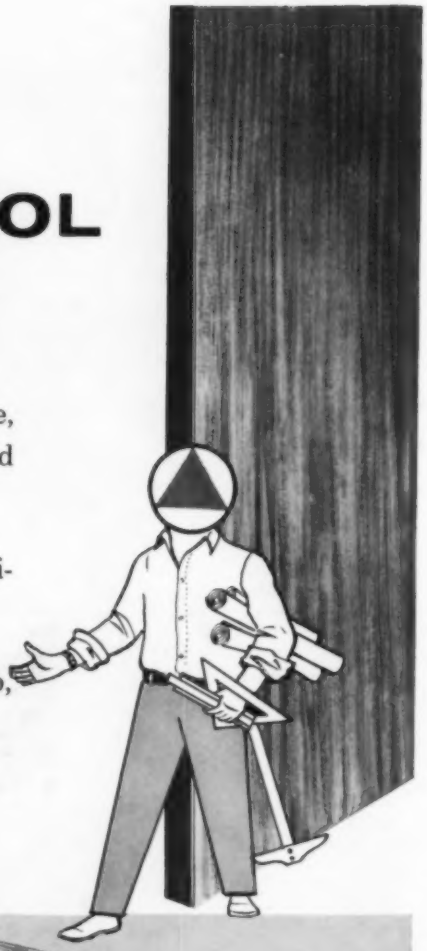
Each nametile holder is a plug-in unit complete with nametile, lamp, socket, reflector and switch or switches as required . . . makes it possible to assemble a unit tailored to your requirements . . . in half the space usually required . . . with a choice of signaling procedures . . . such as flashing lamps for message recall . . . choice of supplementary telephone equipment for voice communication.

Staff In and
Out Register

for complete details, write S. H. Couch Company, Inc. 3 ARLINGTON STREET NORTH QUINCY 71, MASS.

from your

GJ DOOR CONTROL SPECIALIST

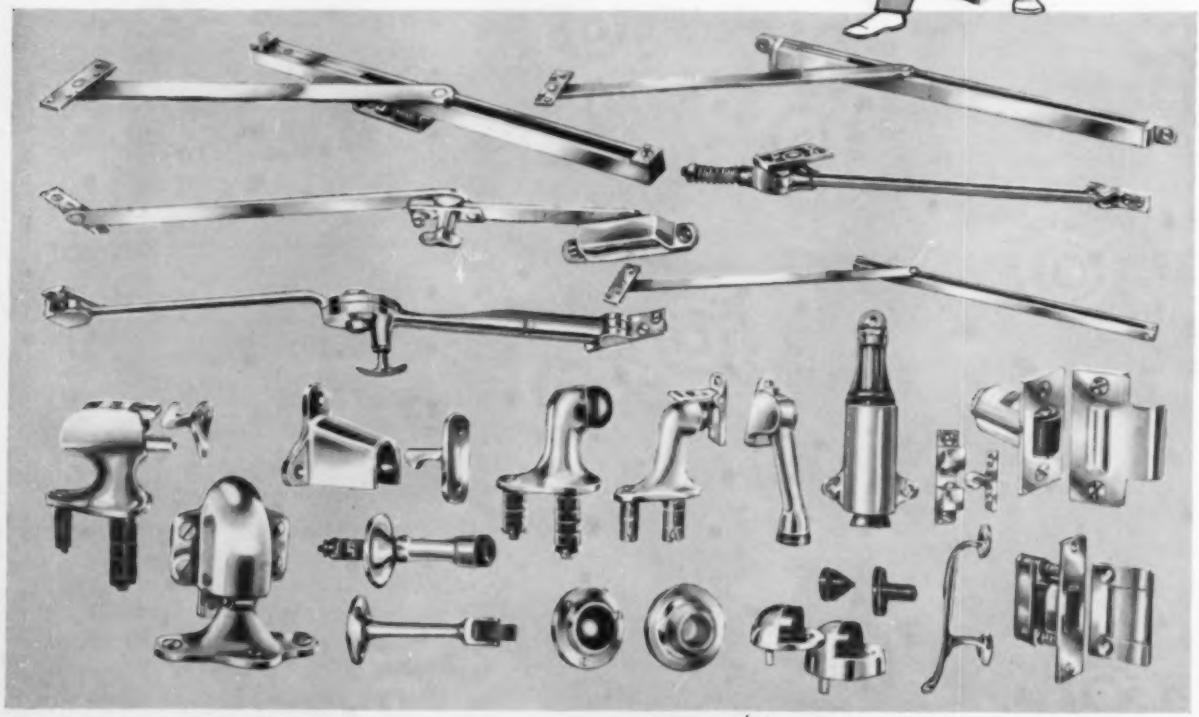


. . . the only complete line of door control hardware, enabling you to select to fit your exact functional and budget requirements.

. . . experienced analysis of every order with engineering aid when required.

. . . quality, the finest in materials and workmanship, consistent for over 35 years.

Your specification means more when you write in ***" . . . shall be GJ."***



GLYNN·JOHNSON CORPORATION

4422 n. ravenswood avenue
chicago 40, illinois

Porta-Cart Air Conditioners Roll Easily to Patient Rooms

An economical and convenient method of air conditioning patient rooms, offices or other small areas is offered in the new G-E Porta-Cart units. The portable air conditioners roll easily from room to room, locked on a sturdy metal cart with four easy-rolling casters. The G-E Easy Mount air conditioner is secured to the carriage and installation is accomplished by rolling the unit to the window, positioning it with the adjusting handle to the window level, up or down, and sliding the carriage supporting the air conditioner into the window opening. Aluminum side panels assure a weathertight seal in any sash-type window. **General Electric, Appliance Pk., Louisville 2, Ky.**

For more details circle #702 on mailing card.

Mobile Coffee Dispenser Has Working Table

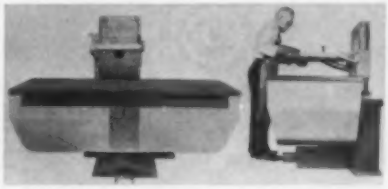
Easily moved on four large casters, the new Blickman Wheelaway Coffee Dispenser offers table-top convenience plus storage. The table-height working area is almost completely unobstructed for setting up cups and other supplies, with only the serving faucet protruding. The unit can be plugged into any standard electric

outlet, and the coffee is kept hot during transfer by the heavy insulation used. The same dispenser can be used for iced tea. Made of all stainless steel, the unit is filled with freshly brewed coffee from an urn by means of an extension filler hose, and holds 20 gallons. **S. Blickman, Inc., 536 Gregory Ave., Weehawken, N.J.**

For more details circle #703 on mailing card.

Standard "Ultima-105" X-Ray Table Built for Heavy Service

Providing the ultimate in efficiency and convenience for the radiologist, with minimum work and effort required, the new Standard "Ultima-105" radiographic-fluoroscopic-spot film table is built to stand up under heaviest hospital service. There is no front leg; hence the radiologist can work comfortably close to the table without bending or strain. Patients are comfortable, and ample protection is provided from radiation for both patient and radiologist because of the completely enclosed body and automatic bucky slot cover. Other features include the new fluoroscopic collimator; easy adjustment of the spot film device, leaving the table top clear; single fulcrum operation for tilting 90-degrees vertical and 15 degrees Trendelenburg, with automatic horizontal stops; magnetic locks with readily accessible controls, and extra large bearings

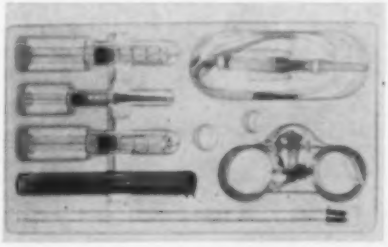


for years of trouble-free service. **Standard X-Ray Co., 1932 N. Burling St., Chicago 14.**

For more details circle #704 on mailing card.

Exchange Transfusion Tray Is Sterile and Disposable

Sterile and ready for immediate use, the Pharmaseal Exchange Transfusion Tray is a compact, complete unit of fully



disposable plastic. It is especially valuable in pediatrics for emergency situations such as Rh incompatibility. Cross infection is eliminated and cleanup and reassembly time are saved, due to its disposability. The required equipment is included in each tray and each item is designed for maximum reliability and ease of use. **Pharmaseal Laboratories, 1015 Grandview Ave., Glendale 1, Calif.**

For more details circle #705 on mailing card.

Boiler Cleaner and Conditioner In Capsule Form

Crest "Jiffy Caps" are a new Boiler Cleaner and Conditioner in capsule form which dissolve instantly to attack and dissolve oil, grease and sludge within the system. The gelatin capsule contains a soluble formula with added cleaning power which aids in reducing cleaning time and product cost, and also removes rust and scale from the boiler. **Crest Mfg. Co., Inc., 4-65 48th Ave., Long Island City 1, N. Y.**

For more details circle #706 on mailing card.

Liquid Bowl Cleaner In Plastic Container

Huntington Liquid Bowl Cleaner is now available in a safe, non-breakable, one-quart plastic container. The re-formulated cleaner now has a pleasant fragrance and a yellow-pink color and keeps bowls sparkling clean. **Huntington Laboratories, Inc., Huntington, Ind.**

For more details circle #707 on mailing card.

Tuberculin Tine Test Is Simple, Accurate and Sterile

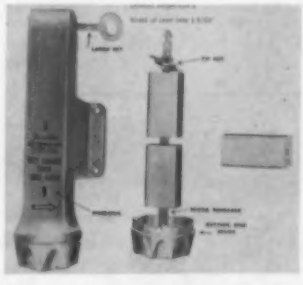
A small, disposable unit is now available for administering the tuberculin skin test to reveal the presence of infection by tuberculosis bacteria. The unit is pressed firmly against the skin, then discarded, thus preventing the possibility of cross infection and saving preparation time. The Tine test is a simple technic as the tuberculin is dried on steel prongs or tines held on the end of a plastic cylinder. Problems of sterility, preservation of antigen potency and depth of injection are overcome with the Tine Test, thus facilitating mass testing as well as testing

of an individual or a small group. **Lederle Laboratories, Div. of American Cyanamid Co., Pearl River, N. Y.**

For more details circle #708 on mailing card.

Soap Grinder Dispensers Reduce Hand Soap Costs

Now manufactured in the United States, the Franklin Soap Grinder Dispensers reduce hand soap costs and improve sanitation and neatness. The dispenser and special formula soap bars are widely used in Europe but were only recently introduced in this country. One bar of the special soap will wash from 350 to 700 pairs of hands. Soap is supplied to the user by one-hand operation of the dispenser, which is installed over the faucet. There are no parts to get out of order, and a window indicates when the soap bar is running out. The carefully engineered dispenser assures simplicity of



use with minimum maintenance. Soap is available in pure castile type, mildly scented, or with hexachlorophene. **Franklin Soap Dispenser Corp., 12 E. Kinzie St., Chicago 11.**

For more details circle #709 on mailing card.

(Continued on page 176)

J&J Strip Sponge Is X-Ray Detectable

Ray-Tec X-Ray Detectable Strip Sponge is now offered in two by four-inch ply to eliminate the refolding of sponges where the strip sponge technic is used. The Ray-Tec Strip Sponge may be opened to two by eight or two by 16 inches without exposing raw edges, and it may also be adapted quickly to the Stick Sponge procedure. **Johnson & Johnson, Hospital Div., New Brunswick, N.J.**

For more details circle #710 on mailing card.

Foldoor Line Now in Peacock Fabric

A new vinyl-coated Peacock Fabric with an attractive, soft appearance is now offered in the Foldoor line of fabric-covered folding partitions. The low price range with style and durability are retained in the Peacock fabric which is available in 17 decorator colors. The tough vinyl surface withstands wear and abuse, is easily cleaned and resistant to fire, cold, fading or discoloration. **Holcomb & Hoke Mfg. Co., Inc., Dept. 815, 1545 Van Buren St., Indianapolis 7, Ind.**

For more details circle #711 on mailing card.

Chieftain Overbed Table Has Sliding Mirror

The vanity section with mirror snaps easily into place in the Chieftain Overbed Table and serves also as a book rest. Quickly adjustable from 30 to 54½ inches in height, the table can be used over all hospital beds, including multiple height, on either right or left side. The three-suspension base provides a solid table footing and maintains rigidity of the table. The plastic laminate top is scratch,

burn, chemical and stain resistant. **American Hospital Supply, Evanston, Ill.**

For more details circle #712 on mailing card.

Plastic Dish Racks Added to Raburn Line

The Raburn line of all-plastic racks for handling cups, plates and other dishes during automatic dishwashing operations and for service is being constantly augmented. New recently are a small sized rack for washing cups, Model 5000 plate rack and a utility rack weighing 2½ pounds. **Raburn Products, Inc., 350 N. Clark St., Chicago 10.**

For more details circle #713 on mailing card.

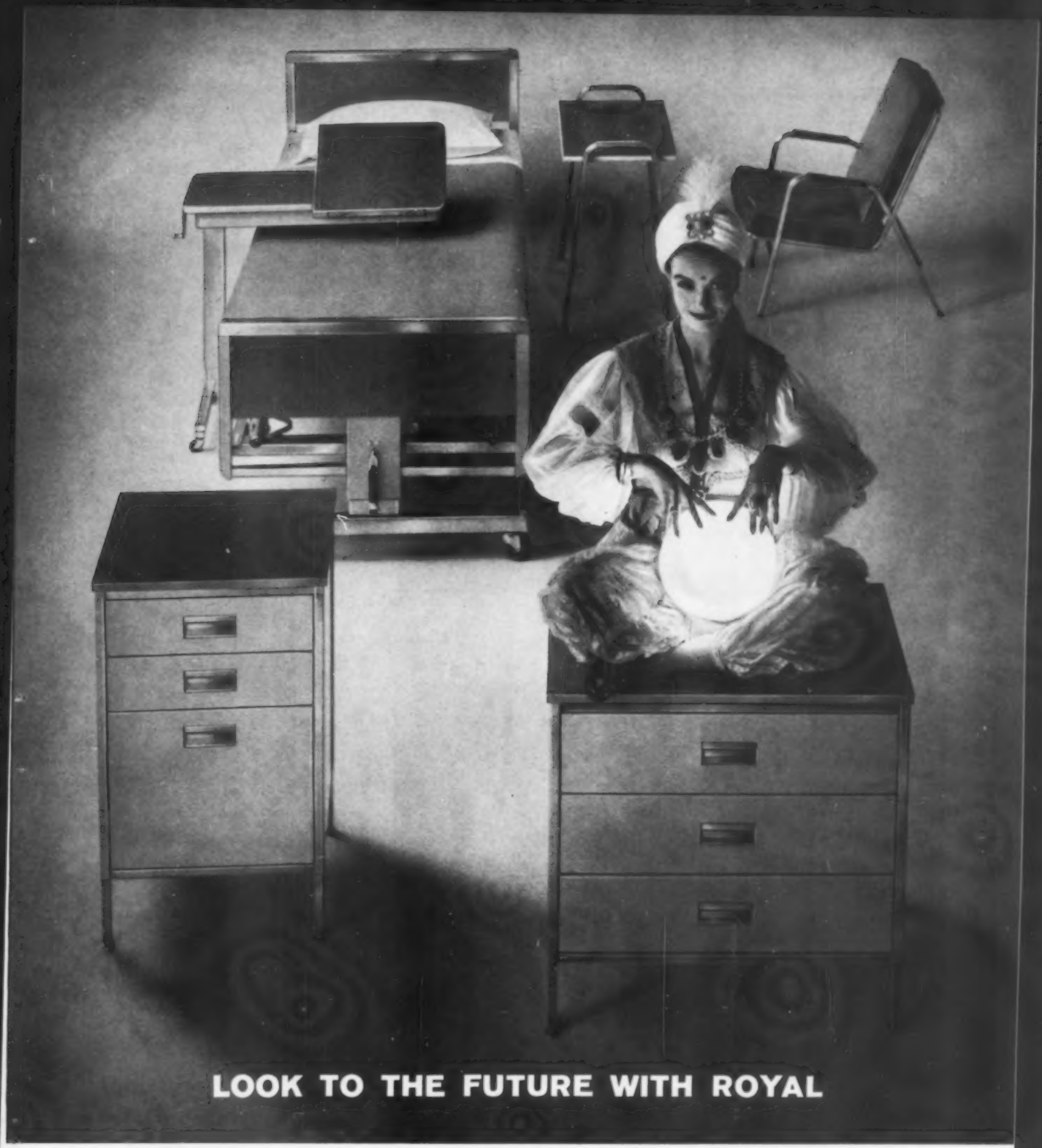
Compact Fire Alarm System Has Low Cost and Modern Design

The new Faraday compact fire alarm system combines modern appearance with lower first cost, reduced installation and maintenance costs, smaller size and increased signal alarm capacity. It is designed to meet the individual requirements of smaller hospitals, nursing homes and other institutions where complex systems are not required. Also new is a complete line of modular pre-engineered systems for more complex applications where needed. The compact alarm is a com-

plete operating system in itself and is offered in three models. The exterior design of the call stations blends with modern architecture and decor and the Alert-O-Glass identification labels change color and give a sensation of animation to those passing the call station, helping to remind personnel of its location when needed. **Faraday, Inc., Adrian, Mich.**

For more details circle #714 on mailing card.

(Continued on page 178)



LOOK TO THE FUTURE WITH ROYAL

NEW CHALET room furniture by Royal is your best investment. The furniture with the built-in future, Chalet is the latest of Royal's complete lines for hospitals and nursing homes. So durable, it's guaranteed for 10 years; so economical, it pays to buy now. Sturdy O-frame construction assures rigid durability and maintenance-free service. Cases are sound-deadened and sealed against dust. Stainless steel drawer pulls are fully recessed. There are no screws to loosen or come out on pulls—or on backs and side panels. Exterior frame in Satin Chrome or Plastelle enamel, interchangeable tops, legs, panels and drawer fronts all assure you of carefree beauty that will last.

Chalet's Four-Drawer Dresser Desk makes the most of room space with good looks and strength to spare. Self-edge Royaloid top defies damage and wear. Write for full information. ROYAL METAL MANUFACTURING COMPANY, Dept. 50-G, **One Park Avenue, New York 16, N. Y. In Canada—Galt, Ontario.** SHOWROOMS: New York, Chicago, Los Angeles, San Francisco, Seattle; Galt, Ontario.

Royal®
HOSPITAL FURNITURE

Picker Syncro-Taper Records Sound and Image

Recording simultaneously the sound and fluoroscopic image of body functions, the new Syncro-taper employs a tape recorder which can be synchronized with the cineradiography attachment on any

image amplifier that uses a Picker Weinberg-Watson projector. Sound and image can then be played back in perfect synchronization. The system permits coordination of the sound of body functions gathered by the stethoscope and the sight of functions gathered by x-rays and fluoroscopy for quicker and more accurate diagnosis. **Picker X-Ray Corp., 25 S. Broadway, White Plains, N.Y.**

For more details circle #715 on mailing card.

Low Cost Fabric Roll Serves Varied Needs

A low cost, disposable, white rayon fabric with many uses in the hospital is supplied in a roll 40 inches wide and 500 yards long. The soft, flame-retardant material can be cut to the proper size for use as cubicle dividers, room separators, disposable aprons, bibs, place mats, tray covers, shrouds, furniture coverings, curtains, surgeons' shoe covers and drop cloths, among others, The fabric has clean cut edges that do not ravel, and is strong yet soft. **Busse Hospital Products, 64 E. 8th St., New York 3.**

For more details circle #716 on mailing card.

Reach-In Refrigerators In Choice of Finish

New self-contained and remote reach-in refrigerators are available with either porcelain or stainless steel exterior and interior finishes or with stainless steel exterior and porcelain interior. A choice of

door arrangements is offered and the units are available in several sizes. New features include front corners and ends which can be individually removed and replaced in case of damage and triple Thermopane on all glass doors. **McCray Refrigerator Co., Inc., Kendallville, Ind.**

For more details circle #717 on mailing card.

(Continued on page 182)

FROM SKIN ANTISEPSIS TO HOUSEKEEPING

Wescodyne with "Tamed Iodine" destroys the widest range of micro-organisms — cleans and disinfects in one step

Wescodyne is formulated with "Tamed Iodine." It non-selectively destroys bacteria, viruses, spores, fungi, *even resistant types of staph.*

Wescodyne improves upon, and eliminates the need for, a wide variety of products. Its strong detergent action combines cleaning and disinfecting in one step.

In solution, Wescodyne is non-toxic, non-staining, non-irritating. And virtually odorless. At recommended dilution, Wescodyne has a rich amber color. As long as the color remains, positive germicidal activity continues.

Astonishingly enough, Wescodyne costs less than 2¢ a gallon at general-use dilution.

WEST CHEMICAL PRODUCTS INC.
WEST DISINFECTING DIVISION

For full information, results of scientific evaluations, and recommended O.R., housekeeping and nursing procedures, write West Chemical Products, Inc., 42-16 West Street, Long Island City 1, New York.

"Wescodyne" and "Tamed Iodine" are Reg. T.M.'s of West Chemical Products, Inc.

Technical Advisory Service
West Chemical Products, Inc.
42-16 West Street, Long Island City 1, New York

Gentlemen: ☐ Please send available literature
☐ Have your representative call

Name_____

Title_____

Address _____

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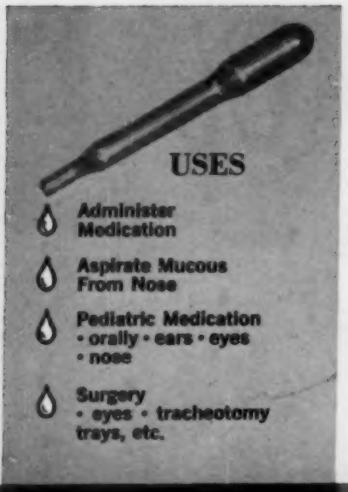
City_____ Zone____ State_____

W



USES

- Administer Medication
- Aspirate Mucous From Nose
- Pediatric Medication • orally • ears • eyes • nose
- Surgery • eyes • tracheotomy trays, etc.

NEW FLEXIBLE DISPOSABLE DROPPER *CUTS COSTS OVER 50%*

The new Fazio one-piece clinic dropper is making new savings for hospitals in money and time while increasing efficiency.

One survey reports: "The low cost of the TFL Clinic Dropper plus the time saving its use affords made it sensible for us to dispose of them after each use. We saved many hundreds of dollars last year."

COMPARE

* SAVE ON PURCHASE PRICE
Lower purchase price than glass droppers.

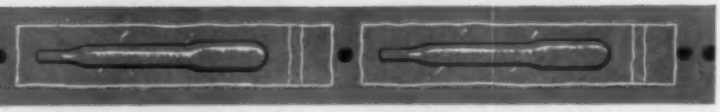
* ELIMINATE MEDICAL HAZARDS
No broken glass injuries to patients and nurses.
No contamination from handling used droppers.
No danger to sensitive membranes.

* CUT HANDLING COSTS
Eliminates: collection, cleaning, sterilizing, storing, redistribution.

* ABSOLUTELY NO BREAKAGE

* SAVE ON STORAGE SPACE

TFL CLINIC DROPPER
OFFICIAL U.S.P. STANDARD



• FLEXIBLE • DISPOSABLE • RE-USABLE • SANITIZED • ABSOLUTELY SAFE •

SEND FOR FREE SAMPLES AND LITERATURE

IMPORTANT PRODUCT FEATURES:

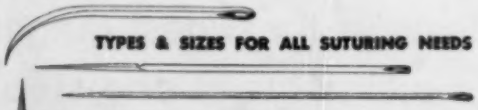
Made of one-piece molded vinyl chloride which can be sterilized by boiling for 5 minutes or autoclaving for 10 minutes.

A chemical added during manufacture prevents bacteria penetration and growth.

• THOMAS FAZIO LABORATORIES • Auburn Street, Auburndale 66, Mass. •

For "A True Eye And A Trusty Point"—

BERBECKER SURGEONS' NEEDLES



TYPES & SIZES FOR ALL SUTURING NEEDS

BERBECKER SURGEONS' NEEDLES are made of fine carbon steel, precision tempered for lasting resilience and sharpness. Eyes and points well designed, sturdily proportioned. Entire needle smoothly finished. Sold only through dealers. See current catalog in "Hospital Purchasing File" or write us.

JULIUS BERBECKER & SONS, INC.,
15H E. 26th ST., NEW YORK 10, N. Y.

...NEW from PORTO LIFT

AN ALL-CHROME PATIENT LIFT

Not a special model . . . but the *new standard* PORTO LIFT, at NO INCREASE IN COST.
New, life-long finish and dependable hydraulic action make PORTO LIFT a "must" for effortless patient handling.

PORTO-LIFT
MANUFACTURING CO.
HIGGINS LAKE, MICHIGAN

012

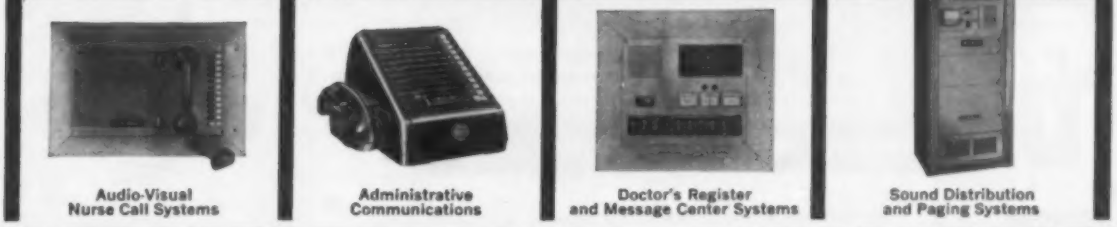
NEW PILLOW SPEAKER WITH REMOTE CONTROLS PUTS SERVICE...SECURITY...ENTERTAINMENT AT PATIENT'S FINGERTIPS

Executone's advanced engineering–and thorough knowledge of hospital problems–has produced this remarkable multi-purpose pillow speaker. The new unit is an audio-visual nurse-call cord set . . . a high-quality sound reproducer . . . radio station and TV channel selector . . . and volume control–all in one. Check these unique features:

- Eliminates the expense and clutter of individual radios. Brings entertainment from one central source. Patient may choose any one of five channels of AM or FM broadcasts, recorded music, chapel services, etc.
- Separate TV control provides simplest possible channel selection.
- Reception is clear, uniform, static-free. Patients in adjoining beds are free to choose radio or TV programs independently, without interference. Patients who prefer to sleep or read are not bothered.
- Nurse call button—and selector buttons—have durable palladium contacts of special design, for utmost reliability.
- Sturdy housing has high resistance to shock and moisture; can be quickly sterilized.
- All patient-nurse conversations utilize the separate wall station, to assure clear uninterrupted voice communication at all times. This ultra-sensitive unit can monitor even the faintest sounds in a patient's room . . . can't be fouled or disengaged.
- Foolproof volume control affects only entertainment; does not alter patient-nurse communication level.
- Bed clamp cannot be removed or lost . . . will not stain or damage linens.
- Entire cord-set is instantly removable . . . can be freely interchanged with other specialized Executone cord-sets (geriatric, explosion-proof, etc.) If the plug is accidentally pulled out, nursing personnel is automatically summoned.
- Wall station lights assure patient of proper call registration and maintenance of his privacy.

FROM EXECUTONE: A REVOLUTION IN BED-CARE COMMUNICATIONS!

ADVANCED EXECUTONE SYSTEMS FOR NEW AND EXISTING HOSPITALS



Audio-Visual Nurse Call Systems | Administrative Communications | Doctor's Register and Message Center Systems | Sound Distribution and Paging Systems

For detailed information, write to:

Executone, Inc., 415 Lexington Avenue, Dept. D-5 New York 17, N. Y.

Name_____

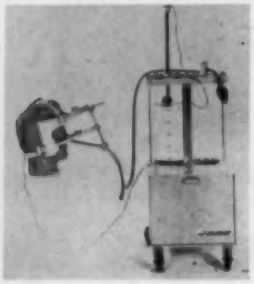
Hospital_____

Address_____ City_____ State_____

In Canada: 331 Bartlett Ave., Toronto

Executone
COMMUNICATION and SOUND SYSTEMS

Automatic Tamponade for Control of Bleeding



The Hemonade is a new automatic tamponade and control appartus designed to provide safe emergency management of bleeding. Balloon tamponade of the esophagogastric varices is controlled with an automatic signalling device which also activates either one of two alarm signals in the event of malfunction. The apparatus consists of a headgear and a cylinder reservoir operating synchronously. The automatic features reduce hours of nursing supervision and there are substantial sayings in blood replacement costs as well as increased patient safety. **Air-Shields, Inc., Dept. 39-9, Hatboro, Pa.**

For more details circle #718 on mailing card.

"Hy-Thermco" in Stainless Steel Cabinet

"Hy-Thermco" water still and storage tank is completely enclosed in a stainless steel cabinet which is designed for convenient wall or counter mounting without brackets. Controls have been simplified and the drain valve permits easy removal of sediment from the evaporator. An exclusive air breather filter gives absolute protection of distillate in the storage tank. **The Electric Hotpack Co., Inc., Cottman Ave., at Melrose St., Philadelphia 35, Pa.**

For more details circle #719 on mailing card.

Compact TelKee Cabinet Holds Two Key Systems

Two complete key systems are held in one cabinet in the new TelKee Dual

Compartment Line. The new cabinet has a rear compartment that has a separate padlock locked door, protecting space for up to 50 different key changes which require maximum security and which must be kept separate from other keys. The front of the cabinet has room for four Swingamatic panels that can control up to 400 key changes, and both the front panels and the rear maximum-security key compartment are controlled, filed and indexed by the standard TelKee system. **P. O. Moore, Inc., Glen Riddle, Pa.**

For more details circle #720 on mailing card.

Patch-O-Print Machine Convertible For Double Use

Easily converted from a permanent property mark machine to an efficient heat-seal patching machine, the Patch-O-Print is designed to save time, money and space. The unique, three-section plate holder makes it possible to use the property name, either an embossed plate or engraved design, in the top section. The lower section accommodates embossed Addressograph plates for date lines or designation for storage or distribution. The patching platen is four by three and one-

half inches, but larger areas can be mended with the use of tapes and successive applications. **Textile Marking Machine Co., Inc., 2204 Erie Blvd., Syracuse, N.Y.**

For more details circle #721 on mailing card.

(Continued on page 184)

Why management was *so Concerned* about Paper Napkins

No one knows better than Management that savings come from a careful regard for costs.

That's why they were concerned when they learned that they could save as much as 20% on paper costs by switching to Fort Howard Napkins in the cafeteria and Fort Howard Towels and Tissue in the washrooms. And to this organization, a saving of 20% was important.

Fort Howard quality Paper Towels, Tissue, and Napkins are available in a wide range of grades in all well-accepted rolls, folds, and styles. This means you can cut costs by selecting the proper grade, fold, roll, pack, and price range that you require to meet your needs exactly.

There is a Fort Howard representative nearby anxious to demonstrate to you how dining room and washroom expenses can be cut, and high standards of service maintained.

Fort Howard Paper Company

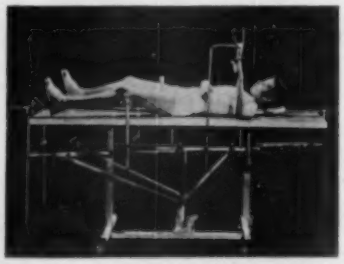
Green Bay, Wisconsin

Sales Offices in New York, Chicago, Los Angeles

America's Most Complete Line of Paper Towels, Tissues and Napkins

Stryker Hydraulic Table Has Attachments for All Casts

Attachments for the application of all types of casts are featured on the new Stryker Hydraulic Cast Table. These are stored compactly underneath the table top when the table is not in use for cast work. Hydraulic action raises and lowers



the patient from the table top and traction can be obtained with internal and external rotation of legs. Lateral rotation of the head while in traction is also provided. The economical table has a pad and it can also be used as an examining table. **Orthopedic Frame Co., 420 Alcott St., Kalamazoo, Mich.**

For more details circle #722 on mailing card.

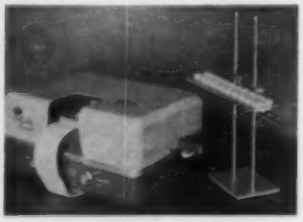
Diversey Amosol XF for Hand Washing Pots and Pans

Compounded of highly effective cleaning and wetting agents, Amosol XF is a new mild alkaline cleaner designed for manual washing of dishes, pots and pans, glassware and silverware. It gives powerful and rapid penetration of contamination found in pot and pan cleaning, yet contains no harsh chemicals harmful to hands. It is safe on all metals, including aluminum, according to report. **The Diversey Corp., 1800 W. Roscoe, Chicago 13.**

For more details circle #723 on mailing card.

Emdeco Prothrombin Recorder Is Fully Automatic

Developed to provide the clinical laboratory with a fast, reliable method of determining prothrombin time, the Emdeco Prothrombin Recorder is completely automatic and can be operated by any qualified laboratory technician with a minimum of instruction. Once the blood sample and a reagent are placed in



the two chambers of the device, a switch is turned and a rocking mechanism mixes the liquids. Automatic operation cuts off the recorder and a permanent record is made in addition to a direct timer dial reading. The recorder was developed by Dr. Alfred W. Richardson, professor of physiology at St. Louis University School of Medicine. **Electro-Mechanical Development Co., 2337 Bissonnet, Houston 5, Tex.**

For more details circle #724 on mailing card.

(Continued on page 188)

SERIES 7000W —WOOD COVERED FOR WOODEN DOORS

SERIES P-7000 —WITH METAL COVER FOR METAL DOORS

Norton® Series 7000 Closers.....
The Custom Look for every door

Only Norton's Series 7000 can assure you of a perfect match between door and closer throughout your entire building. Available with metal covers painted to match or contrast with the finish of metal doors. Available chrome plated to match other door hardware. Available covered with wood to assure a perfect match between door and room panelling.

Get complete details from your Norton representative today or mail coupon.

NORTON DOOR CLOSERS
for complete Architectural Compatibility

1021

Norton Door Closers, Dept. MH-71
372 Meyer Road, Bensenville, Illinois

Please send Manual N-1 ☐
Have my representative call ☐

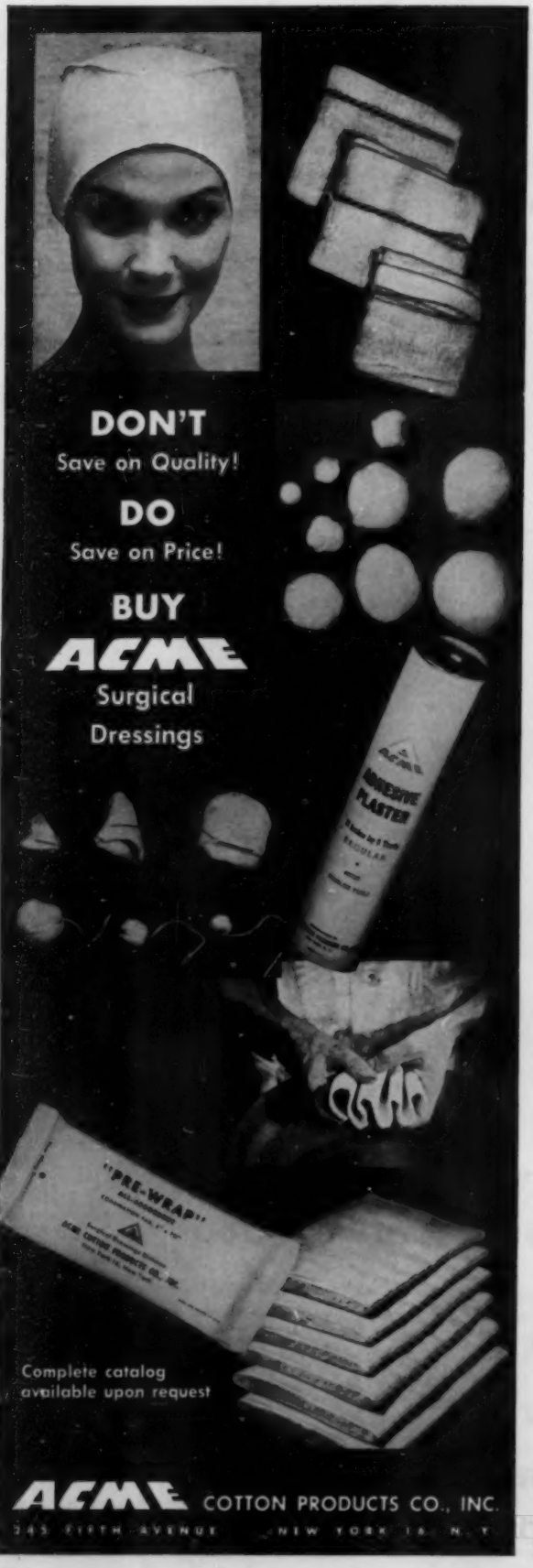
Name_____

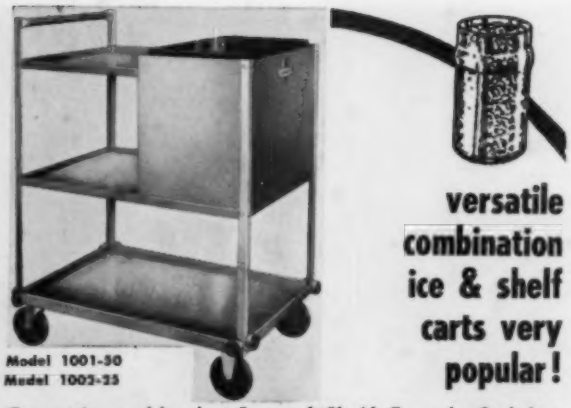
Firm_____

Address_____

City_____ State_____

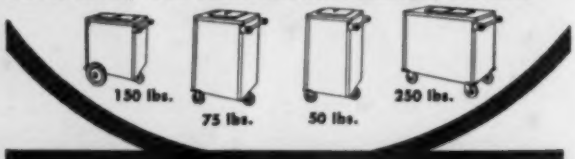
For additional information, use postcard facing back cover.





versatile combination ice & shelf carts very popular!

Gennett's combination Ice and Shelf Carts in Stainless Steel. Two Models-50 lb. or 25 lb. Ice Chests. 300% increase in purchase last year proves popularity. Versatility unsurpassed for every service. Ice-Glasses (clean and used)-Pitchers-Trays-Water and Nourishments. Bedside choice with maximum sanitation at nominal cost. Write for catalog of Ice Carts and Cabinets. GENNETT AND SONS INC., One Main Street, Richmond, Indiana.



GENNETT Ice Carts

If you find disposables too expensive the answer is

steriphane TECHNIQUE

THE STERIPHANE TECHNIQUE is the only complete sterilizing system available today; it is used to process more needles and syringes than all other methods combined.

STERIPHANE processed heat sealed envelopes are your assurance of sterility. Packaged needles are delivered to the nursing station in a stainless steel dispenser insuring compact handling and accurate control at the same time protecting the needle point.

The proper size packaged syringe is easily selected and protected through the use of specially designed STERIPHANE syringe baskets.

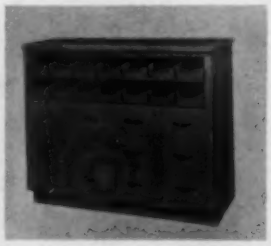
The finest reusable equipment is processed economically with the finest and only complete sterilizing system . . .

Free trial and consultation available

steriphane CORPORATION OF AMERICA
84 FIFTH AVENUE • NEW YORK 11, NEW YORK

Time-Saver Magazine for Pharmacy Dispensing

The magazine dispenser unit of the McKesson Storage and Dispensing Cabinets for the pharmacy contains inclined fiberglass sections for magazine feed of prepackaged pharmaceuticals. When the front package is removed, another slides into place, saving time and keeping supplies within immediate reach. The dispensers are fitted with movable partitions to accommodate packages of various sizes and shapes and the lower unit has 12 storage draws for additional supplies. The sectional unit fits with others to form a pharmacy set up to serve any requirements. **McKesson & Robbins Inc., 155 E. 44th St., New York 17.**



For more details circle #725 on mailing card.

Amtico Vinyl Flooring in Colors Unlimited

A special service for vinyl flooring is offered by Amtico in Colors Unlimited. Floors may be matched to decorating plans by sending a swatch of the desired hue to the manufacturer for matching exactly in plain or terrazzo. Also new in the line are Flagstone rock-ridged vinyl, colored Travertime, and five species of Forest Wood. The latter is actually grooved to the precise depth of dressed lumber with the gloss of hand-rubbed patinas. **Amtico Vinyl & Rubber Flooring Div., American Biltrite Rubber Co., Trenton, N.J.**

For more details circle #726 on mailing card.

Lucky 7 Oven Has Pan-Jam-Ban Feature

The 1961 model Middleby-Marshall Lucky 7 Oven features a Pan-Jam-Ban, an immediate-acting safety device to eliminate oven damage caused by carelessly loaded overhanging pans. Special venting prevents blast-out of heat when the door is opened. The new model also features a thicker front wall, automatic belt-adjustment, a new tray indicator dial with special reset feature, and a new heat-resistant motor drive. **Marshall Oven Co., 739 W. Adams St., Chicago 6.**

For more details circle #727 on mailing card.

(Continued on page 190)

Roll-Top Linen Cart Helps To Minimize Infection

A slatted aluminum door, which rolls into the new Roll-Top Linen Cart, permits access to the contents when in storage without moving the unit, and eliminates hinged doors which might protrude into hospital aisles. Fabricated from anodized Temper-Luminum, which is exceptionally strong, yet light in weight, the cart is anodized to assure cleanliness and to minimize infection from staph and other bacteria. Compartments for individual needs are supplied and double handling is eliminated, providing easier inventory control and linen accessibility. **Bucks County Enterprises, Inc., Quakertown, Pa.**

For more details circle #728 on mailing card.

All Purpose Bonding Kit for Maintenance Jobs

Maintenance jobs indoors and out can be quickly and economically handled with the new All Purpose Bonding Kit. The maintenance man can permanently bond or repair almost any building material, including concrete, brick, masonry, stone, steel, cast iron, copper and the like. Applications include everything from filling cracked floors to bonding playground equipment or repairing leaking pipes. The easily carried kit contains three kinds of epoxys: Concresive #1, Concresive #2 and Metlhesive. **Adhesive Engineering, 1411 Industrial Rd., San Carlos, Calif.**

For more details circle #729 on mailing card.

Mobile Maintenance Station has Vacuum Chamber

The Cartavac, a complete mobile maintenance service station, features a built-in vacuum chamber which cleans dry mops of every size and can be removed for use as a vacuum or blower. Other features include shelf space for storage of cleaning utensils, equipment and supplies, and a canvas bag or barrel attachment for waste collection. **The M. D. Stetson Co., 64 E. Brookline, Boston 18, Mass.**

For more details circle #730 on mailing card.

(Continued on page 192)

When wax contains Du Pont anti-slip LUDOX® floors are safer...and they buff mirror-bright!

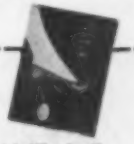
Wax made with Du Pont "Ludox" colloidal silica buffs to a brilliant shine, just like any other fine wax, yet it's perfectly safe to walk on. Tiny silica particles of "Ludox" provide millions of gripping points for sure traction underfoot, but other wax properties remain unchanged—there's the same easy application, durability and high gloss.

"Ludox" is Du Pont's registered trademark for its colloidal silica—an ingredient used by formulators of quality waxes. Floor wax containing "Ludox" is available everywhere. If you'll mail the coupon, we'll send more information and a list of suppliers.

DU PONT LUDOX® colloidal silica

REG. U.S. PAT. OFF.

BETTER THINGS FOR BETTER LIVING . . . THROUGH CHEMISTRY



E. I. du Pont de Nemours & Co. (Inc.)
Industrial & Biochemicals Dept., Rm. 2545MH
Wilmington 98, Delaware

Please send more information on floor waxes with "Ludox" and a list of suppliers.

*Name*_____

*Firm*_____

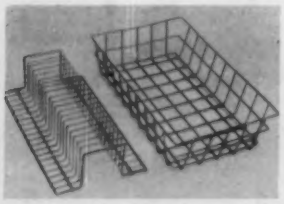
*Address*_____

*City*_____ *State*_____

For additional information, use postcard facing back cover.

McCulla Glove Rack Comes in Two Sections

Developed for quick, safe handling of gloves during and after sterilization, the



McCulla Glove Rack comes in two sections. Gloves are placed in a removable inner rack held in an outer utility basket. Because the rack can be removed for drying, the autoclave can be re-used immediately. The inner rack may be placed directly on sterile storage shelves or on a cart for delivery without handling packaged gloves, and the outer rack may be used alone for sterilizing packaged syringes and other items. The racks, formed of lightweight strong stainless steel, nest for storage. **Edward Weck & Co., 135 Johnson St., Brooklyn 1, N.Y.**

For more details circle #731 on mailing card.

Laminating Method Offered with Thermo-Fax Machines

A new process for laminating papers, cards, charts, records, photographs and other written or printed documents with plastic film is now possible on Thermo-Fax machines. Existing copying machines made by the firm laminate without special equipment or adjustments, making it possible to protect papers and to prevent tampering. **Minnesota Mining & Mfg. Co., Dept. SO-138, 900 Bush Ave., St. Paul 6, Minn.**

For more details circle #732 on mailing card.

Two Change Makers in One in Standard Line

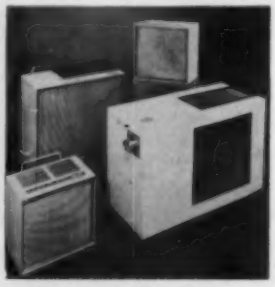
Two manually operated Change-Makers are built into one cabinet in the new Standard Duo-Changer. Combining the single Change-Maker with the triple

Multi-Changer, the unit is designed for use in attended, busy locations. Other new units introduced by Standard include a new line of single, double and triple Maximum Security Change-Makers with heavier cabinetry, common-front design, interchangeable units and cartridge loading. They are constructed of heavy steel with a quadruple locking mechanism for use in unattended locations. Loading and servicing are simplified, yet the special locks protect entry to the interior. **Standard Change-Makers, Inc., 422 E. New York St., Indianapolis 2, Ind.**

For more details circle #733 on mailing card.

Air Filter Devices Help Kill Airborne Bacteria

New filters and circulators which make it possible to reduce substantially the number of airborne bacteria, including staphylococcus aureus, are now available. The concept involves the continued circulation of air through bactericidal filters to ensure protection against excessive bacteria build-up in air circulated in patient rooms and other hospital areas. Tests



indicate that practically all airborne contamination is killed when trapped in the new "Permachem" filters, which are adaptable to virtually all hospital equipment. The Permachem agent is bonded to the filter during manufacture. **Fram Aire Corp., Providence 16, R.I.**

For more details circle #734 on mailing card.

(Continued on page 196)

EVERYONE IS HAPPIER WITH FLEET ENEMA

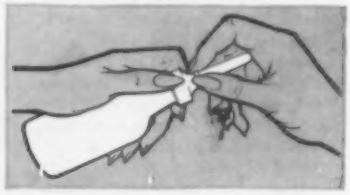
because it's as easy as 1.2.3

Pre-lubricated, anatomically correct 2-inch rectal tube avoids injury

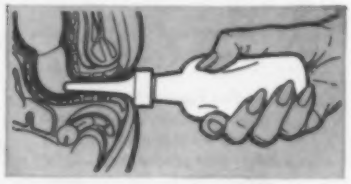
Check valve regulates flow

4½ fl.oz. of precisely formulated solution provides quick, thorough cleansing without patient discomfort

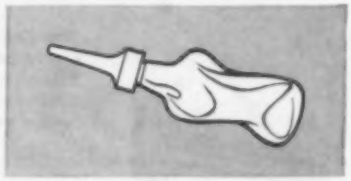
Compact squeeze bottle unit — no loose or moving parts



1. ***Ready to use*** . . . no preparation necessary . . . just remove protective cover



2. ***Easy to administer*** . . . by nurse or patient . . . takes less than a minute . . . just squeeze bottle with one hand



3. ***Disposable*** . . . simply discard unit after use . . . eliminates cleanup and sterilization

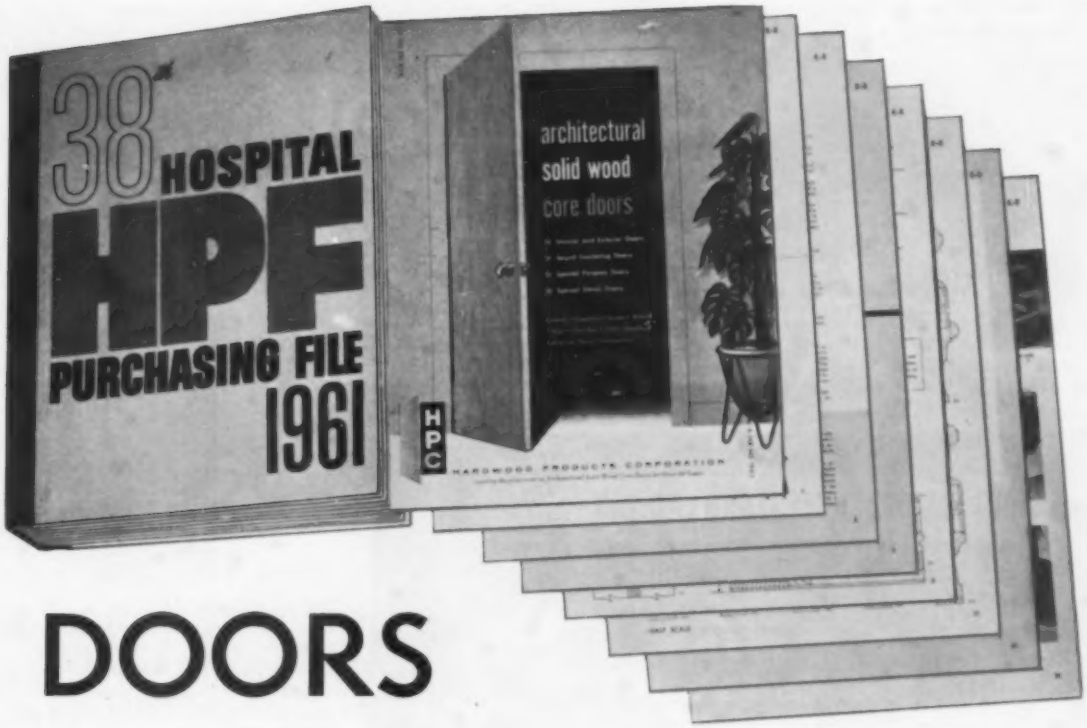
100 cc. contains: 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate in 4½-fl.oz. squeeze bottle. *Pediatric size,* 2¼ fl.oz. *Also available:* Fleet Oil Retention Enema, 4¼-fl.oz. ready-to-use unit containing Mineral Oil U.S.P.

FLEET® ENEMA

READY-TO-USE SQUEEZE BOTTLE

C. B. FLEET CO., INC. Lynchburg, Va.

For additional information, use postcard facing back cover.



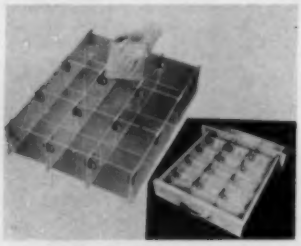
DOORS

FOR ALL HOSPITAL NEEDS

In the current edition of Hospital Purchasing File on your desk (it should be there) turn to Catalog Number E-3. You will find 16 pages in full color with detailed illustrations, drawings and specifications of the doors made by Hardwood Products Corporation of Neenah, Wisconsin. Along with 214 other suppliers of routine and once-in-a-while products, Hardwood Products Corporation is putting full buying information in the one place where hospitals have been looking for buying information since 1919. These suppliers are making it easy for you to find the products you want, to evaluate and compare. Be sure Hospital Purchasing File *is* on your desk, or available in your office. Be sure all administrative and departmental people know where they can find it, know what it contains and how to use it.

SEE OUR CATALOG IN THE HPF HOSPITAL PURCHASING FILE

Drawer Sub-Dividers Made Of Durable Plexiglas



New Sub-Dividers for hospital casework drawers are removable and easy to arrange in partitions of widely varying sizes. Special chromium plated clips are designed so that they can be inserted in any position on the longer Plexiglas strips, and smaller cross dividers are inserted as required by drawer storage needs. The clear Plexiglas is shatterproof, durable, easily cleaned and sterilized, can be inserted and removed in minutes, and permits clear visibility to all partitions. **Maysteel Products, Inc., Mayville, Wis.**

For more details circle #735 on mailing card.

Molded Paper Plates Have "Plasti-Sized" Coating

The improved "Plasti-sized" plates in the Keyes Standard and Royal Chinet line are treated by a new method that coats the pulp fiber rather than the surface and substantially increases resistance to hot juices and gravies. The plates are completely water, oil and grease resistant, and have superior aging qualities. **Keyes Fibre Co., Waterville, Maine.**

For more details circle #736 on mailing card.

Flask Washer Has Jet-Pressured Cycle

The #6720 Flask Washer cleans six 250-ml. to 3000-ml. solutions flasks per 50-second cycle through an exclusive high-pressure jet washing principle which assures complete removal of all soils without injury to the annealed surfaces. Washing is accomplished by recirculation of hot detergent solution under pressure through the jet assemblies. The washer is constructed of all welded vinyl and stainless steel with vinyl steel front panel and backsplash. **The MacBick Co., 243 Broadway, Cambridge 39, Mass.**

For more details circle #737 on mailing card.

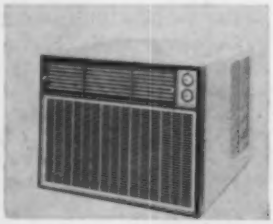
Win-Gard Floor Finish Practically Eliminates Bacteria

Win-Gard is a new floor finish which was shown by laboratory test to reduce bacteria count 99.6 per cent. Floors are left with a lustrous finish which is non-slip and water resistant while remaining bacteria resistant for long periods. The self-sanitizing action helps prevent the growth of dust-borne bacteria, thus reducing bacteria spread. Win-Gard can be used effectively on all types of floors and a free Culture Test-Kit is offered to users. **Windsor Wax Co., Inc., 611 Newark St., Hoboken, N.J.**

For more details circle #738 on mailing card.

Amana 250 Series Air Command Is Window-Type Air Conditioner

The Amana 250 Series Air Command is a window-type air conditioner which provides high cooling capacity, yet is easily installed in double-hung windows as small as 28 inches wide. Features include an eight-position, extra sensitive thermostat, large cooling coils, and exclusive Amana Silent-Aire Turbine for quiet operation. **Amana Refrigeration, Inc., Amana, Iowa.**

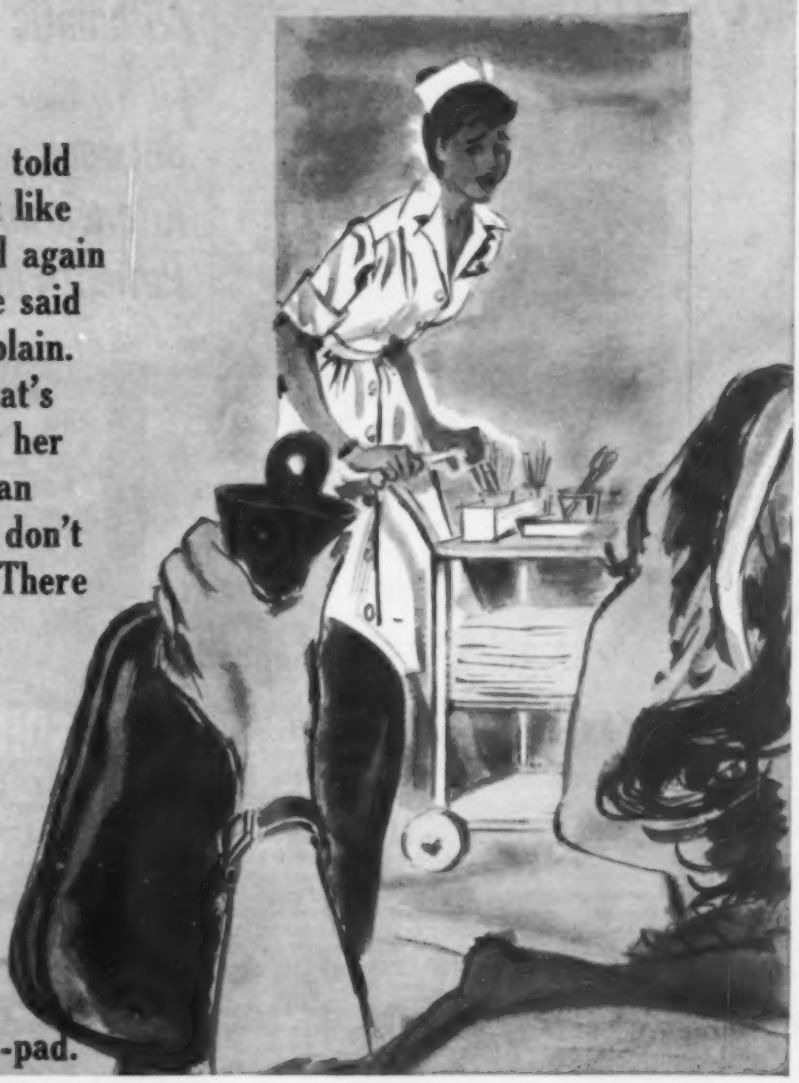


For more details circle #739 on mailing card.

(Continued on page 199)

"Hey Nurse.... my hot water bottle's cold"

O. K. . . . now I've been told . . . "Oh Nurse . . . I don't like to complain but it's cold again and I've got a pain" She said she doesn't like to complain. Well Brother, it's me that's getting the pain. It's not her fault, really, but what can I do? Why in the world don't we get something new? There must be a simpler and easier way than filling bottles the whole live long day. Why can't we get one that's automatic, where the temperature is not so erratic, there is, you say? Well, I'm sure glad. Praise the Lord and pass the K-pad.



aquamatic K *pad*

Eliminates the tedious ritual of filling, checking and replacing. Flexible pad drapes and moulds lightly to contours to provide maximum contact. Several sizes available including 14" x 3" model for rectal compresses and post partum use. The "set and forget" Control Unit maintains desired temperature, constant to within 1°F. Contains a three week supply of distilled water and is whisper quiet. For complete information write Gorman-Rupp Industries, Inc. or ask your American Hospital Supply Corp. representative.

GORMAN-RUPP INDUSTRIES, INC., BELLVILLE, OHIO

DISTRIBUTED NATIONALLY BY { American Hospital Supply Corporation and V. Mueller and Company

ROTARY MACHINES

process all surgical gloves ...regular or disposable for less than 1½¢ each

By far the lowest cost, most dependable method for washing, drying, and powdering rubber gloves...yes, even "disposables". Less than 1½¢ per glove including all materials and labor! Three companion, single-purpose machines, each with 150-glove capacity, eliminate delays. No waiting between loads. All stages of processing can be carried on simultaneously. And glove life is materially extended... reducing need for large inventories.

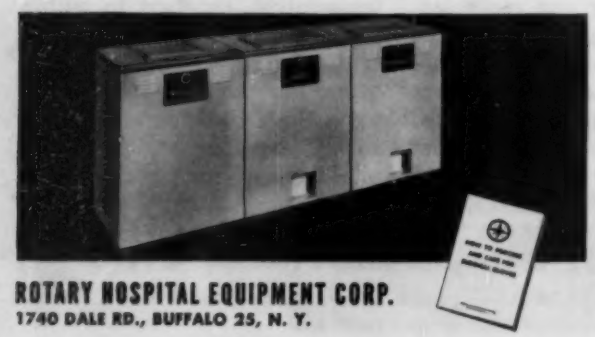
Matching stainless steel units are attractive, sanitary, and durable. In hospitals of 100 beds or more, they repay their cost the first year... while creating substantial savings over hand methods.

WASHER—The only machine designed specifically for surgical gloves. Unique tub design and pulsating action clean gently, thoroughly... three times faster than by hand.

DRYER—Revitalizes gloves. Thermostatically controlled warm air dries three times faster than by hand. Unique air circulation keeps operating parts clean, promotes safety.

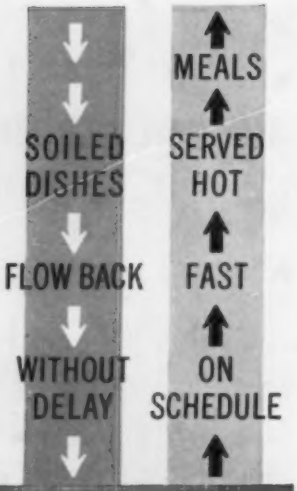
POWDERER—Applies uniform coating inside and out... ten times faster than by hand. Airtight. No powder escapes.

FREE: Glove Processing Manual, giving latest, recommended procedures, sent on request. Also, descriptive literature on each machine and other Rotary hospital products.

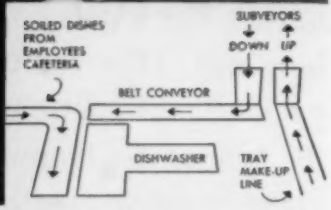


ROTARY HOSPITAL EQUIPMENT CORP.
1740 DALE RD., BUFFALO 25, N. Y.

The Automatic Link Between Kitchen and Patient Floors



OLSON *mechanized* **FOOD and DISH HANDLING EQUIPMENT**



Meals are served hot, on schedule and with less help at Milwaukee's Children's Hospital—thanks to an Olson Conveyor System which *automatically* links the kitchen with all five patient floors. The cycle begins with an assembly line make-up conveyor which speeds trays to an ascending subveyor. Trays of soiled dishes are later returned via a descending subveyor and connecting horizontal belt conveyors which deliver to the dishwasher. Another conveyor brings soiled dishes from the employee dining room where the employees bus their own trays.

An Olson System streamlines tray make-up, simplifies diet supervision and permits pin-point scheduling of patient feeding . . . also reduces the noise of tray handling and eliminates elevator bottlenecks at meal time.

Write today for complete information on how an Olson System can be engineered—*economically*—to meet the individual requirements of your hospital and help you cut operating costs.

OLSON CONVEYORS *manufactured by:* **Samuel Olson Mfg. Co., Inc.** 2423 Bloomingdale Ave., Chicago 47, Ill.
DIVISION OF CHERRY-BURRELL CORPORATION

Vacuum Center for Recovery Room Is Effective and Flexible

Any combination of equipment required for specialized recovery rooms can

be quickly set up for either permanent use or to be moved from outlet to outlet using Oxequip flush service quick connect outlets. The Vacuum Center illustrated consists of two oxygen service outlets and four vacuum service outlets with provision for any type of inhalation therapy or drainage. Set up for recovery room use with specialized cardiac surgery patients, it includes two thoracic drainage units, one intermittent suction regulator and bottle, one vacuum regulator drainage and aspiration unit and two oxygen flowmeters, one of which is equipped with a Humidijet. **Oxygen Equipment and Service Co., 8335 S. Halsted St., Chicago 20.**

For more details circle #740 on mailing card.

Improved Wall Deterger Weighs Only 25 Pounds

A redesigned and improved model of the Von Schrader Wall Deterger, constructed of stainless steel and other noncorrosive metals, weighs only 25 pounds and is highly mobile and easy to transport.

Practical for institutions, the machine cuts maintenance and cleaning costs as one man can clean 6,000 square feet of wall space in one day. A new detergent available for use with the Wall Deterger requires only two operations, causes no streaks, cannot harm paint, sanitizes without odor, and leaves walls in condition for repainting. **Von Schrader Mfg. Co., 16th St. and Junction Ave., Racine, Wis.**

For more details circle #741 on mailing card.

Automatic Gas Water Heaters for Institutional Use

The new Unihot automatic gas water heaters, Model U90 and U21, are designed to supply a constant volume of high temperature water. They are ruggedly constructed for years of continual heavy duty service, designed for flexibility in any installation, and multiple units assure an uninterrupted supply of hot water. Additional units may be installed as needs increase. **Unimac Co., 892 Miami Circle, N. E., Atlanta 5, Ga.**

For more details circle #742 on mailing card.

Lightweight Allergy Medal Warns of Sensitivity

The Allergy Medal is made of lightweight Alcoa aluminum with a warning sign against drug sensitivity printed in red on one side. Space is provided on the other side to engrave the allergies. The disc is non-toxic, won't rub off on skin or clothing, does not bend, scratch or ignite, and is not affected by perspiration, fresh or salt water, soap or detergents. **John M. Lee, Ligonier, Pa.**

For more details circle #743 on mailing card.

Instant Potato With Milk Is Complete Product

A completely prepared food, Heinz Instant Potato With Milk is ready to serve

by simply adding water and whipping the mixture to the desired consistency. Instructions are printed on every label and the institutional product is supplied in #10 cans, six cans to the case. All seasoning, in addition to whole milk and non-fat milk solids, is included in the new improved formula. **H. J. Heinz Co., P.O. Box 57, Pittsburgh 30, Pa.**

For more details circle #744 on mailing card.

Two-Step Stool-Seat Has Handrail Attachment

A new device, the Self Ease Safety Two-Step Stool-Seat with handrail attachment, gives support to patients in getting into and out of bathtubs at easy step intervals, and can double as a shower seat. The two steps provide a rugged, convenient assist for safe, easy elevation, and the unit is helpful for entering and leaving hospital beds. It is constructed of heavy duty chrome-plated steel tubing with

vinyl covered steps and non-skid rubber tips. **Self Ease Units, Inc., 975 Park Ave., New York 28.**

For more details circle #745 on mailing card.

(Continued on page 200)

Colson Wheel Chair Is Ruggedly Constructed

Designed to eliminate riveted joints, the new low-priced Colson Rambler model wheel chair is so constructed that its "X" cross braces are brazed to the seat rails with lower ends supported on pivot tubes. Attachment of casters to the lower portion of the frame tube affords maximum strength and facilitates maintenance. Frame and brace construction are of tubular steel and the lightweight sturdy chair is designed for years of rugged use. **The Colson Corp., 7 S. Dearborn St., Chicago 3.**

For more details circle #746 on mailing card.

"Pocketphone" Is Two-Way Miniature Radio

The "Pocketphone," a two-way miniature radio that actually fits into a pocket, broadcasts and receives at distances up to one mile in the Citizens Broadcast Band and can be used for paging and handling messages within the hospital. The transistorized unit has a built-in "PowerPak" battery that may be recharged and will last up to one year without replacement. Microphone and speaker are built-in and a battery charger is included with the set. **Globe Electronics, Div., Textron Electronics, Inc., Council Bluffs, Iowa.**

For more details circle #747 on mailing card.

Safety Sides Fold in Minimum Space

A new safety side, constructed of anodized high strength aluminum or of steel,

can be fitted to or removed from a hospital bed by one person in less than one minute. Once installed it can be easily raised to a height of 21 inches, where it is automatically held by a simple positive locking action, and folds to a compact three inches when not in use. In the lowered position it affords complete clearance of the mattress and at the same time gives full access to the under bed area. **Hospital Inventors of Canada, 1931 Mattawa Ave., Summerville, Ont.**

For more details circle #748 on mailing card.

Stainless Steel Cleaner Is Quick and Easy to Use

Cleaning time is reduced considerably with the new Majestic Stainless Steel Cleaner and Polish which is supplied in a handy 16-ounce aerosol container for convenience and economy. When used to clean stainless steel surfaces, they are left with a protective polish which resists staining, water-spotting and fingerprinting. **Majestic Wax Co., 1600 Wynkoop, Denver 2, Colo.**

For more details circle #749 on mailing card.

Polypropylene Drinking Set Is Autoclavable

A white carafe with a locking cap, which is easily removed to serve as a five-ounce cup, forms an autoclavable drinking set of heat resistant polypropylene unaffected by autoclaving above 250 degrees F. The clean, modern lines of the carafe leave no crevices for dirt or germs

to collect. **Bel-Art Products, Industrial Road, Pequannock, N. J.**

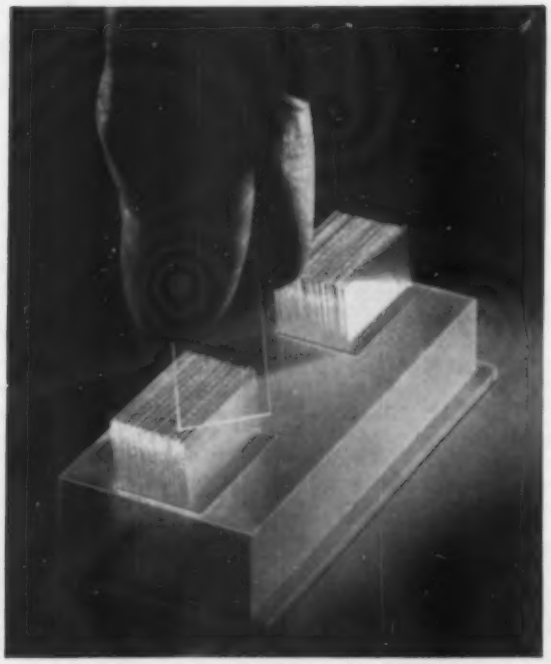
For more details circle #750 on mailing card.

(Continued on page 202)

Now you can get No. 1½ thickness CORNING® cover glass at new, low prices

Leading manufacturers of microscopes say this thickness gives best results with high-power dry objectives.

Now, for the first time, you need not pay a premium price for the cover glass thickness which most manufacturers use to prefocus their instruments' optical systems and recommend that you use for optimum performance.



You can get No. 1½ thickness of our finest quality CORNING cover glasses—in the very same sizes of squares, rectangles and circles as our standard No. 1 and No. 2 thicknesses—for less money than any other No. 1½ covers on the market. Squares and rectangles are only $2.30 per ounce. A saving of $1.35 over the old price.

You can save still more by combining orders for No. 1½ cover glass with those for your PYREX® laboratory ware needs, to get quantity discounts as high as 23.5%.

We package squares and rectangles to give you cleanliness and convenience. For most of your applications, CORNING cover glasses are clean enough to use as they come out of the dispenser box. They come out easily, too, because they are packed for convenient one-at-a-time removal by the edges.

For more information on CORNING cover glasses, call your laboratory supply representative or write for Supplement No. 3 to Catalog LG-2. Laboratory Glassware Department, 3807 Crystal St., Corning, N. Y.

CORNING GLASS WORKS
CORNING MEANS RESEARCH IN GLASS

PYREX® laboratory ware ... *the tested tool of modern research*

Pharmaceuticals

Zarontin

A new anticonvulsant succinimide, ethosuximide, Zarontin is primarily useful in controlling petit mal epilepsy. The product can be used alone or in combination with other anticonvulsants. Clinical tests with Zarontin showed complete or practical control of seizures in 63 per cent of cases, with improvement noted through a reduction of the number of attacks in an additional 17 per cent. Zarontin is supplied in soft gelatine capsules for oral administration. **Parke, Davis & Co., Jos. Campau at the River, Detroit 32, Mich.**

For more details circle #751 on mailing card.

Pramilets, Filmtab

Pramilets, Filmtab, and Pramilets-F, Filmtab, are vitamin-mineral supplements for pregnancy. Pramilets is a phosphorus-free dietary supplement with a new formula providing increased amounts of elemental iron, pyridoxine, ascorbic acid and cobalamin. Primalets-F, Filmtab, include folic acid in addition to the other vitamin-mineral elements. Both have Filmtab coating which makes possible an unusually compact tablet for better patient acceptance. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #752 on mailing card.

Plegine®

Plegine® is a white, odorless powder, soluble in water, methanol and ethanol, recommended in the management of obesity wherever excessive appetite is responsible for overweight. Highly effective in treating simple obesity, it may also be used to advantage when excessive appetite or weight aggravates associated conditions, such as diabetes, pregnancy and the like. No adverse effects on blood pressure, heart rate and respiration were noted in clinical tests. It is supplied in table form. **Ayerst Laboratories, 22 E. 40th St., New York 16.**

For more details circle #753 on mailing card.

Antivert Syrup

A new dosage form of the anti-vertigo drug Antivert is now available in Antivert Syrup. Effective in treating vertigo, Meniere's syndrome and those conditions of apprehension and mental confusion which may arise from nicotinic acid deficiency, the new syrup dosage form is designed for patients who find difficulty in taking tablets. **J. B. Roerig & Co., 800 Second Ave., New York 17.**

For more details circle #754 on mailing card.

Latex-Trichina Reagent

A new rapid slide test antigen for use as an aid in the diagnosis of trichinosis is now available in Latex-Trichina Reagent. Prepared from polystyrene latex and an extract of Trichinella spiralis, it has been processed to give rapid and clear-cut reactions with serum specimens containing antibodies to trichina. Tests are easy to perform and the new reagent reacts to the high titers found in active infection, not the low titers encountered in dormant sensitization. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #755 on mailing card.

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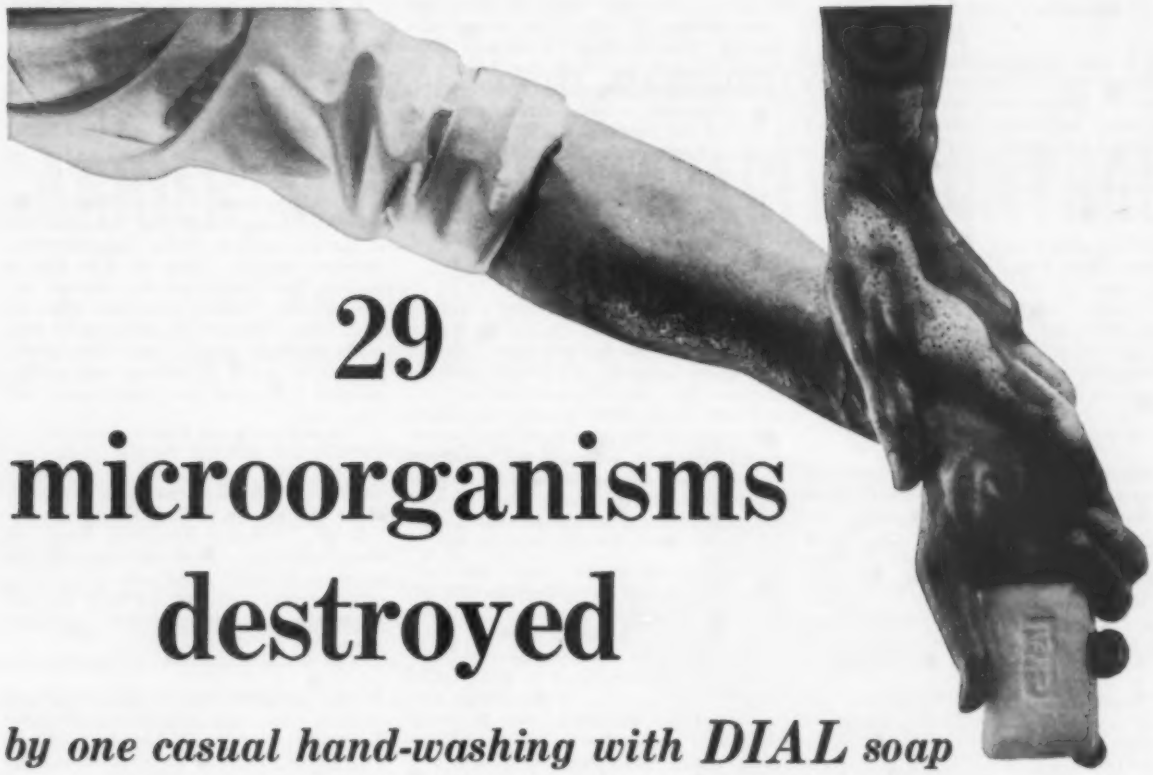


29 microorganisms destroyed

by one casual hand-washing with DIAL soap

Routine use of Dial by patients and personnel suggested as an aid in eliminating one source of infection

New and more extensive tests have established that Dial soap destroys a wider range of gram-positive and gram-negative microorganisms, and controls their growth, than any other bar soap designed for hospital use. Latest tests show that Dial is effective against 29 strains with a casual hand-washing. These organisms include *six strains of Staph aureus*, along with others which resist antibiotics.

The antibacterial ingredient in Dial—a synergistic combination of hexachlorophene and trichlorocarbanilide has long been known for its effectiveness against skin bacteria that cause perspiration odor. Dial's antibacterial properties have been familiar to physicians for a considerable time. And now, this new evidence sharply points up the benefits of Dial for routine use by hospitalized patients and hospital personnel.

With its unique antibacterial benefit you might expect to pay extra for Dial—but you don't. You can trim costs even more by choosing the bar sizes suited to your hospital needs. Three hospital-tested sizes are available—1, 1¼ and 2½ oz.—also others. Write our laboratory at address below for technical and clinical information.

Antibacterial spectrum of Dial soap

Microorganism	Soap Concentration For Total Kill, ppm* Dial
1. S. aureus (No. 209) **	10
2. S. aureus 388010 ***	10
3. S. aureus 388014 ***	25
4. S. aureus 388062 ***	25
5. S. aureus 388115 ***	10
6. S. aureus 388128 ***	10
7. S. lutea	3
8. E. coli	5000
9. S. oranienburg	4000
10. S. typhosa	9000
11. S. pullorum	4000
12. P. mirabilis	6000
13. P. vulgaris	8000
14. S. marcescens	4000
15. S. flexneri	5000
16. P. fluorescens	9000
17. B. cereus	10
18. B. megaterium	10
19. B. s. v. niger	25
20. B. s. v. atterimus	10
21. B. ammoniagenes	10
22. S. faecalis	25
23. M. phlei	10
24. M. smegmatis	10
25. N. catarrhalis	10
26. C. albicans	4000
27. S. cerevisiae	4000
28. T. interdigitale	50
29. Airborne mold	1000

*Soap concentration: Casual handwashing: 80,000 ppm (average) deliberate scrub: 120,000

**F. D. A. Strain (biological standard).

***Antibiotic-resistant strains supplied thru the courtesy of Mt. Sinai Hospital, New York, New York.

from the Industrial Soap Division of

ARMOUR AND COMPANY

1355 W. 31st Street, Chicago 9, Illinois

Literature and Services

• A new **six-page, full-color bulletin** published by the Jamison Cold Storage Door Co., Hagerstown, Md., describes the company's lightweight plastic cooler and freezer doors, easily handled by women employes, and available in five colors. Specification charts are included.

For more details circle #756 on mailing card.

• A new sound and color 16mm motion picture, **"Feel Free,"** with a planned running time of 20 minutes, is concerned with correct machine dishwashing procedures. Designed as an educational aid for use in food service departments, the film is available for showing through DuBois Chemicals, Inc., 634 Broadway, Cincinnati 2, Ohio.

For more details circle #757 on mailing card.

• **Bulletin NM-230.040** describes and illustrates the new **"Handy" Neonatal Service Unit,** a twin bassinet with a resuscitator, aspirator and other equipment for care of infants, available from National Cylinder Gas Div., Chemetron Corp., 840 N. Michigan Ave., Chicago 11. The bulletin discusses the use of the resuscitator and lists features of the entire unit.

For more details circle #758 on mailing card.

• **"Home Care of the Incontinent Patient"** is the subject of a 24-page illustrated booklet offered by the Professional Products Div., Chicopee Mills, Inc., 47 Worth St., New York 13, to hospitals and physicians.

For more details circle #759 on mailing card.

• A comprehensive story of glass and glass-ceramics is told in the revised edition of **"This Is Glass,"** a 68-page illustrated booklet reviewing the history of glass and detailing the basic types of glass. The attractive, colorful cover invites a study of the contents which, in addition to factual information, include exceptional photographs of glass art. A section on Pyroceram, the new glass-ceramic material, is also presented in the booklet offered by Corning Glass Works, Corning, N.Y.

For more details circle #760 on mailing card.

• A 12-page brochure, giving a cursory concept of the complete line of equipment especially designed by American Laundry Machinery Industries, Cincinnati 12, Ohio, to meet the particular needs of any size and type of hospital or other institution, also discusses the specialized and personalized service in **planning and equipping hospital and institution laundry departments** to assure the greatest benefits with the most conservative investment.

For more details circle #761 on mailing card.

• A variety of special menus, table settings, recipes and party ideas for quantity feeding planners is presented in a new 80-page guide entitled **"Special Occasions,"** offered by the Food Service Director, John Sexton & Co., P.O. Box JS, Chicago 90. Outstanding special events serving plans are presented from 18 prominent food service heads, and include national dishes, table plans, sketches of service and floral arrangements and comments by the institutional feeding specialists.

For more details circle #762 on mailing card.

• A 14-page guide to **proper selection of orthopedic and fracture treatment equipment** in outfitting new hospitals is available from Orthopedic Equipment Co., Bourbon, Ind. The lists suggested are for 100-bed general hospitals and are divided into Surgical and Cast Room Central Supply.

For more details circle #763 on mailing card.

• The dimensions of all 1960 and 1961 model cars are taken into consideration in the new edition of the comprehensive, 40-page manual, **"How to Lay Out a Parking Lot."** Published by Western Industries, Inc., Parking Gate Div., 2742 W. 36th Place, Chicago 32, the manual contains detailed sketches and photographs for various types of parking, with recommended individual stall dimensions and other data.

For more details circle #764 on mailing card.

• How much liquid is left in a partially used drum can be gauged by a new **wall-chart** prepared by U.S. Industrial Chemicals Co., Technical Literature Dept., 99 Park Ave., New York 16. The colorful chart is designed specifically for U.S.I.'s ethyl alcohol but can be used for any liquid with a similar coefficient of cubical expansion.

For more details circle #765 on mailing card.

• The complete line of horizontal and vertical steam unit heaters manufactured by Ilg Electric Ventilating Co., 2850 N. Pulaski Rd., Chicago 41, is described and illustrated in **Bulletin DB4-101.**

For more details circle #766 on mailing card.

(Continued on page 206)

It's new and exclusive...

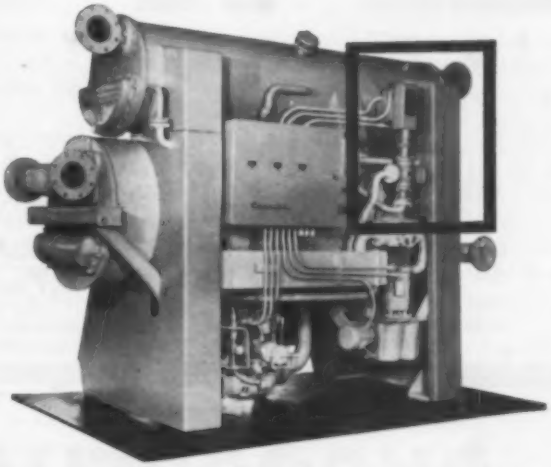
CARRIER SOLUTION CAPACITY CONTROL

with Automatic Absorption Refrigeration cuts operating costs to an all-time low!

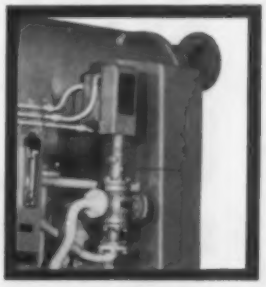
Through lower steam consumption per ton of refrigeration when working at partial load, Carrier Solution Capacity Control cuts operating costs. Since refrigeration equipment seldom works continuously at full load, the savings it effects can be substantial. With it, full advantage may be taken of the lowest possible steam rates. Results: Maximum economy and peak efficiency.

Two other advantages of Solution Capacity Control: (1) Steam pressure always remains constant. There's no need for manual or costly automatic steam control valves. (2) In addition to reducing steam consumption at partial loads, this Carrier development lowers the temperature of the condenser water leaving the machine and also eliminates bleeding of air into the condensate system. Results: Longer life, reduced water treatment requirements and few shutdowns.

Available for either electronic or pneumatic operation, Solution Capacity Control is now standard on all Carrier Automatic Absorption Liquid Chilling Packages. It can be installed with only minor adaptation at job-site on existing Carrier units. A Carrier representative will be glad to give you complete information about it. Write Carrier Air Conditioning Company, Syracuse 1, New York. In Canada: Carrier Air Conditioning Ltd., Toronto 14.



For air conditioning or process cooling, the Carrier Automatic Absorption Liquid Chiller uses low-pressure steam, high-temperature hot water or other hot liquids to produce refrigeration. Capacities: 50 to 1000 tons.



Solution Capacity Control System precisely controls machine output by reconcentrating only enough lithium bromide solution to handle the refrigeration load. When operating at partial capacity, the excess portion of full load solution is bypassed through the capacity control valve – positioned automatically in response to chilled water demands. Capacity control avoids all the additional heat loss which would accompany the unnecessary heating and cooling of the solution.

Carrier Air Conditioning Company

• Bulletin No. H-282 on the Castle-Bendix Sonic Energy Cleaning System for hospitals is now availbale from the Wilmot Castle Co., 1945 E. Henrietta Rd., Rochester, N.Y. How the equipment operates to clean surfaces of instruments, glassware and small utensils, with saving in labor, is discussed with other details of micro-cleanliness.

For more details circle #767 on mailing card.

• How high temperatures are achieved without high pressures with the Vapor Hi-R-Temp liquid phase heater is discussed in the new eight-page **Bulletin No. 4023** published by Vapor Heating Corp., 80 E. Jackson Blvd., Chicago 4. Complete specifications, with information on economies in piping and increased safety, are included.

For more details circle #768 on mailing card.

• **Bulletin 401L** on the **Lab-Flo Model BL-4010-1 Needle Valve Hose Cock** for fine control of rare gases and standard services on laboratory furniture is offered by T & S Brass & Bronze Works, Inc., 128 Magnolia Ave., Westbury, L.I., N.Y. The catalog sheet includes a detailed analysis released by the United States Testing Co., Inc., and a specification data sheet is also available.

For more details circle #769 on mailing card.

• Chairs and tables for dining and lunch rooms are shown in the new condensed six-page catalog of **Howell Contract Furniture.** Over 50 illustrations of Howell modern metal contract furniture with the new Encore square tube and the round tubular steel frames are shown, together with chairs with molded plywood seats and backs or with polyfoam cushioning and a choice of colorful Naugahyde upholstery. The catalog is available from The Howell Co., Contract Dept., St. Charles, Ill.

For more details circle #770 on mailing card.

• A revised edition of **"Grounding Facts,"** an eight-page illustrated booklet published by The Arrow-Hart & Hegeman Electric Co., 103 Hawthorn St., Hartford 6, Conn., contains the latest information on National Electric Code requirements. It is designed to benefit those who specify, install, use and inspect electrical appliances and equipment.

For more details circle #771 on mailing card.

• A new bulletin on **Calgon Instant-Dri,** a solid form rinsing agent that handles easily and eliminates water spotting, is available from the Calgon Co., Hagan Center, Pittsburgh 30, Pa.

For more details circle #772 on mailing card.

Suppliers' News

The Hard Mfg. Co., Box 427, Buffalo 5, N.Y., manufacturer of hospital and other institutional furniture, announces **Underwriters Laboratories approval** of the new **All-Ektrik automatic electric bed,** designating it completely safe for both patient and nurse to operate under all normal hospital conditions, including use with oxygen.

For more details circle #773 on mailing card.

Westinghouse X-Ray Dept., 2519 Wilkens Ave., Baltimore, Md., announces its complete line of **ultrasonic cleaning units** for medical, hospital and clinical use will be marketed through surgical supply houses in key cities.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

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USE THIS CARD — (We pay the postage)

I am interested in the items circled— **July, 1961**

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NAME _____ TITLE _____

INSTITUTION _____

ADDRESS _____ ZONE _____ STATE _____

☐ **Enter my One Year Subsription To Modern Hospital ($5), Foreign ($7)**

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(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File 1961 Edition.

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PERMIT NO. 137
CHICAGO, ILL.

BUSINESS REPLY MAIL
No Postage Stamp Necessary If Mailed in the United States

POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL

1050 MERCHANDISE MART

CHICAGO 54, ILLINOIS

FOR TECHNIC PERFECTION IN BLOOD COLLECTION...

NEW B-D VACUTAINER®

sterile disposable needle

reduces risk of cross-infection— a new, factory-sharp needle for every venipuncture

a B-D DISCARDIT product

SAFE
re-use is precluded... plastic hub cannot withstand conventional re-sterilization

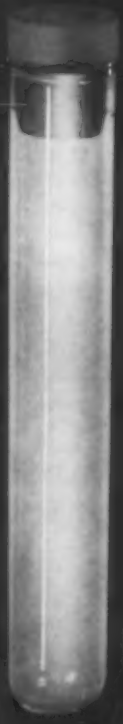
UNIQUE
the first truly disposable needle available for use with evacuated tubes

ECONOMICAL
preparation of needle and post-use handling eliminated

CONVENIENT
ready for immediate use... individually packaged in handy, sterile units

and B-D VACUTAINER®

evacuated specimen tube



offers the **simplest** and most **efficient** means of obtaining quality blood specimens

PROVEN BY OVER 10 YEARS' EXPERIENCE

SUPERIOR STOPPER
easy to clean...
easy to use...
easy to remove...

STRAIGHT SIDE TUBE
easy pouring... easy pipetting of serum, plasma or whole blood... easy removal of clots

WIDE RANGE OF USES
six different sizes and 45 different anticoagulants and preservatives ...color-coded according to usage

BECTON, DICKINSON AND COMPANY
RUTHERFORD, NEW JERSEY

No paper laminations to chip and cause sharp, unsightly and unsanitary edges

THE CATER TRAY SUPREME

Made with a new exclusive bisphenol polyester formula

IT WILL:

- withstand long and repeated steam autoclavings up to 300°F.
- resist surface attack by strong detergents and acids.
- retain its strength, eliminating damage if dropped while still hot from washing.

IT WILL NOT:

- warp, distort, pit or craze under steam pressure.
- fade, bleach, chalk, or powder—colors are permanent.
- chip, peel or delaminate its **clean** through color.

The Cater Tray Supreme is available in four handsome pastel colors, six sizes and personalized, if you wish. It is priced competitively with other premium-type trays. All Cater Trays are made by Houston Reinforced Plastics Co., Inc., a pioneer in plastics.

See for yourself: Send for an actual sample which you can put to your own tests, or call your dealer for a demonstration. See for yourself the significant labor and replacement costs you will save with Cater Tray Supremes.

HOUSTON REINFORCED PLASTICS CO., INC.
P. O. BOX 19486
HOUSTON 24, TEXAS

Gentlemen:
I would like to know more about your Cater Tray Supreme. Please send me a sample we can test to our own satisfaction ☐.

Name of Institution

Address

City Zone State

Your Name